EFFECTS OF BUDGET CONSTRAINTS ON QUALITY AND QUANTITY OF HEALTH CARE SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

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EFFECTS OF BUDGET CONSTRAINTS ON QUALITY AND QUANTITY OF HEALTH CARE SERVICES

Monday, May 15, 1989

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Northport, NY

The subcommittee met, pursuant to notice, at 9 a.m., Department of Veterans Affairs Medical Center, Northport, NY.

Present: Representatives Mrazek (presiding), Hochbrueckner, and Downey.

OPENING STATEMENT OF HON. ROBERT J. MRAZEK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK. ON BEHALF OF HON. G.V. (SONNY) MONTGOMERY, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS

Mr. Mrazek. On behalf of the House Committee on Veterans' Affairs, I would like to convene this official hearing of the U.S. House of Representatives. We are meeting today to discuss the important issues affecting the Veterans' Administration hospital care system.

We have some very important testimony that we will be receiving today. I think it would be very helpful and illuminating for those who have come to the hearing, as well as through our official record of this hearing, to inform the other Members of Congress as to the basic needs that are going to have to be met in the future with respect to the delivery of medical care for our veterans' population in the United States.

The official record will be kept open for 5 days so that those of you who have written statements that you would like to submit will have an opportunity to do so. They will become part of the official record of this hearing by the House Committee on Veterans' Affairs.

We have two members of the Veterans' Committee who are hoping to be with us a little later. As many of you are aware, we had some unprecedented fog conditions this morning and Congressman John Rowland from Connecticut, as well as Congressman Morrison are hoping to be with us today at the hearing. They are presently grounded in Connecticut, but will hopefully be here a little later.

The first thing that I would like to do is ask everyone to rise for the Pledge of Allegance.

[Pledge recited.]

Mr. **Mrazek**. We have a formal statement from our colleague from Nassau County, Congressman Ray McGrath who had to fly back to Washington this morning unexpectedly and will not be able to be with us.

Without objection his statement will be inserted in the record.

[The statement of Congressman Ray McGrath appears on p. 50.]

Mr. **Mrazek**. At this time I would like to recognize my colleague, Congressman Thomas J. Downey, from the second congressional district of New york.

OPENING STATEMENT OF HON. THOMAS J. DOWNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. **Downey**. Thank you, Bob. I don't think that there is a more important task for a Member of the Congress of the United States than to make sure that the promises that have been made by the Government to its citizens have been kept. That is why we are here, to make sure that the promises that have been made to veterans are kept.

I think you will find during the course of the hearing some testimony that may conflict with your thoughts about the way things have worked. I can speak on behalf of my other colleagues when I say that we are interested and believe that the very foundations of democracy rest on the confidence that we all have in the Government, and to a lesser extent, but certainly an important extent, the promises that are made to veterans are part of that foundation of democracy. You hold our feet to the fire, and this is an example of your lobbying efforts, whether it is from Lindenhurst, Copaigue, or Bay Shore, the veterans told me they have concerns. That is why Bob convened this hearing.

I want to congratulate committee chairman G.V. "Sonny" Montgomery, and you, Bob, for organizing this hearing. I look forward to the testimony that we will receive and look forward to some tough questions from the witnesses.

Mr. **Mrazek**. Thank you, Congressman Downey.

I now turn to my colleague George Hochbrueckner, from the first congressional district, for any opening statement he would like to make.

OPENING STATEMENT OF HON. GEORGE HOCHBRUECKNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. **Hochbrueckner**. Thank you, Bob.

As a U.S. Navy enlisted veteran myself, and being a member of the House Armed Services Committee, I am pleased to be here as a member of the Long Island Congressional Delegation. Veterans health care is a very important issue to us. We have a large population of veterans here on Long Island. There are many good things happening in terms of the nursing home in Stonybrook and other areas. We are very concerned. I am pleased to be here, and I am ready to listen.

Thank you, Mr. Chairman.

Mr. **Mrazek**. I would like to, at this point, apologize to those people who have requested an opportunity to testify today at this hearing who will not have that opportunity. We had requests from more than 20 elected officials here in Nassau and Suffolk County to testify, as well as many veterans and representatives of veterans' organizations. It is difficult to have to say no to those requests, because much of the testimony would have been important, and worthwhile. Much of it will be submitted to us for the formal record in the form of written testimony.

However, I am going to be convening a second hearing on this issue within the next month or two, at which time there will be an opportunity for many people who are not going to be able to testify today to have their voices heard on the issue.

After having reviewed all of the written testimony that we will be hearing today, it is fair to say that much of this testimony is going to be unpleasant, but it wouldn't appear to me, at least, that this is a story of mismanagement. It is, rather, a failure to keep faith with our Nation's veterans on the part of our Government, and the struggle to provide quality care with a dramatically reduced budget for the Veterans Administration hospital care system. It is my hope, at least, that this record will serve a very important purpose in making sure that Congress understands veterans' needs in the future, and that the administration and Congress provide the resources necessary to make sure that quality care is provided to all of our veterans.

At this point, I would like to call on our first panel to please come up. It consists of Albert Washko, Director of the Northeastern Region of the Veterans Health Services and Research Administration, from the Department of Veterans Affairs; William Manley, Jr., Director of the Veterans Center here in Northport; Gregory J. Haag, Director of the Health Care Staff, Development and Retention, Department of Veterans Affairs; and, finally, Dr. Edward Fischel, Chief of Staff of the Medical Center here in Northport.

Gentlemen, will you please come to the witness table. We have received your formal statements for the record. I would simply ask that you summarize those statements to the best of your ability, in terms of bringing out the key points that you would like to present to the committee and we will then have an opportunity to raise questions.

Mr. Washko.

STATEMENT OF A PANEL CONSISTING OF ALBERT B. WASHKO, DIRECTOR, NORTHEASTERN REGION VETERANS' HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS' AFFAIRS; WILLIAM H. MANLEY, JR., DIRECTOR, DVA MEDICAL CENTER, NORTHPORT, NY; GREGORY J. HAAG, DIRECTOR, HEALTH CARE STAFF DEVELOPMENT AND RETENTION, DEPARTMENT OF VETERANS' AFFAIRS; AND EDWARD E. FISCHEL, M.D., CHIEF OF STAFF, DVA MEDICAL CENTER, NORTHPORT, NY

STATEMENT OF ALBERT B. WASHKO

Mr. WASHKO. Thank you very much.

Dr. Gronvall, the Chief Medical Director of the Veterans Health Services and Research Administration made an appearance before the Senate Veterans' Affairs Committee last summer, as well as before the House Veterans' Affairs Committee. In both of those appearances, Dr. Gronvall made the point that over the past decade, the funding for the Veterans Health Services and Research Administration has been basically flat; that there have been no increases in funds to veterans' medical care, after considering inflation. We contrasted this to the private sector, to the Medicare program, to the Department of Defense Medicare programs, in which there has essentially been a real 20-percent increase in expenditures after taking into account inflation.

So you can see that over the past decade veterans medical care is roughly one-fifth short of the resources that our brothers and sisters in the private sector have to deliver care. And at the same time, however, we are held to the same standard of care. So therein, I would suggest to you, is one of the major points that ought to be made known at this hearing, that we are significantly short with respect to the private sector, while at the same time we are held to that same standard.

What does that mean for someone like me? I'm responsible for the VA medical centers in the northeast. Now, being short about 20 percent means that, in effect, I don't have funds to run about five of my hospitals, while at the same time I do that. And so throughout hospitals in the northeast, we have major funding shortages.

The second point I would like to make is that because of the prevailing salary levels in the Federal Government, we are at a significant disadvantage in attempting to recruit people to Government service, and we are at a significant disadvantage in trying to retain them. Paul Volker, who was Chairman of the Federal Reserve, as you gentlemen I am sure are well aware, recently chaired a very presitigious commission on public service. There were a couple of ex-presidents on that Commission, several chief executive officers from private industry, and they made the point that the salary levels and the salary system itself is severely flawed in the Federal Government. They suggested that the Federal Government begin to move toward a system of regional or localized pay. I would like to suggest one of the mechanisms that would be of great assistance to the hospital directors in the northeast, would be to have a system of regional or localized pay or pay differentials so that we can pay competitive wages or more competitive wages in New York City, Boston, and some of the other high cost areas in the northeast region.

I think that basically summarizes my written testimony. I would be happy to respond to any questions that you might have.

Mr. MRAZEK. Thank you Mr. Washko. I would like to now call on Bill Manley, Jr., the Director of the Medical Center. Mr. Manley.

[The prepared statement of Mr. Washko appears on p. 52.]

STATEMENT OF WILLIAM H. MANLEY, JR.

Mr. MANLEY. Thank you, gentlemen.

My name is Bill Manley. I have been at Northport since October of 1985. I have been with the Department about 25 years. I would like to make a few comments this morning about the budget. Over the last 4 years, I went back to actually April of 1985, which was our fiscal year 1986 target lines. Our recurring base at that time was $69.7 million, and would support an employment level of 1,850 employees. As of March 31, 1989, this recurring base has grown, has grown to $85.5 million. However, that will only support an employment base of approximately 1,826 employees.

This is a $15.8 million increase. That amounts to approximately a 5 percent gross rate, annualized and compounded annually. However, it does support 24 fewer positions. About 90 percent, a little over 90 percent of this increase is $15 million. It is itemized in the hand out that I have given you, and the written testimony. I did that for a purpose. You can see that it is very much earmarked. There is no flexibility, I believe, in this $15 million, it represents salary increases, special salary rates, which we will talk about a little later.

A majority of the remaining $1.5 million, went to open an additional 40 bed long-term care unit, in anticipation of opening our new nursing home, and minor expansion to the Satellite MHC Program, Alcohol OP Program and the VICTORS Program. The losses over the same time frame, money that was taken away from the recurring base, amounts to $7 million. This, once again, has been itemized in the written statement. Once again budget losses over the last 4 years have been itemized in the written statement. If there's any questions on that, I'd be glad to answer them later. It amounts to $7 million.

I would like to talk a little bit about the non-recurring, as we refer to it, part of the budget and the non-personal service dollars. The non-personnel service dollars of our budget has decreased 5 percent over the last 2 years; there is a 5-percent decrease. In some of the non-recurring item dollars in the budget, such as equipment, and about which Dr. Fischel, Chief of Staff will be talking, have decreased, especially over the last 2 years. Prior to that, it was funded at about a level of 1.5 percent of the total dollar investment on our non-expendable equipment listing. We have over $20 million in equipment in this facility. When the budget was normal, we still were receiving somewhere between 1.5 and 3 percent of the total equipment listing; that's not a very large sum of money.

Recurring maintenance problems is where we can see a decrease happening here in Northport. This is the program that takes care of buildings and the facility that we are proud of today. This building of 1930 vintage is usable because of the amount of money we put in the maintenance program to keep the facility in good repair. In fiscal year 1986, $842,000 was spent for this purpose in fiscal year 1987, $491,000; last fiscal year, 1988, $310,000. This year, I have nothing programmed in my balance. We have some projects ready for bidding. However, we are awaiting the results of a supplemental bill which is pending in Congress right now for this fiscal year.

Another non-recurring item on the budget has to do with community nursing home care. We do contract with a local nursing home. In fiscal year 1986, we were funded at a level of 92 average daily census of the number of patients on any given day during that year. The funds utilized in that program amounted to $4.1 million. The per diem rate for veterans in the 1988 fiscal year, $118 per day per patient under contract at a nursing home.

Fiscal year 1989, this year, we are funded at a level of 83 average daily census (ADC), $4.3 million, and the average daily per diem rate this year is running around $143 per day per patient. During the last fiscal year, 1988, we were given permission to fund up to a 100 ADC.

I would like to talk very briefly about work load. In the summer of 1986, we had a less than successful recruitment season for registered nurses, mainly because of the salaries. We will talk about recruitment and retention a little later on. As the fall approached, our inability to hire RN's impacted on our operation. We were forced to close some beds temporarily. Eventually, we closed an entire ward, 11A, which is a long-term care ward, discharging some of the patients to the community nursing home care program, and bringing others into our acute care setting.

This resulted in delaying some elective admissions and created some revenues lost under the RAM system, which is used to allocate funds.

In February of 1987, the RN special salary rates were approved and recruitment started being successful again. By April, we had opened up at least half of the beds in ward 11A, and by June of 1987, we were fully operational in 11A again.

We also have trouble at this time with LPN's and nursing aides. In the summer of 1986, the Chief of Surgery left our employment. By the beginning of fiscal year 1987, we were starting to notice a decrease in work load there. We had many recruitment efforts under way, but we were unable to fill the Chief of Surgery's position for nearly 2 years. Finally, in the beginning of fiscal year 1988, with the help of the affiliate, Stonybrook University, there was a surgeon on staff who met the qualifications, who was interested in being our Chief of Surgery. Stonybrook was willing to supplement his salary substantially. He is on board now and approved as Chief of Surgery as of March of 1988. And our Surgery Program is definitely showing a marked improvement over 2 years ago.

Of course, during the fiscal year 1987, when we lost some work load in acute medicine and surgery, our out-patient work load was also affected. This year we are starting to show recovery in our outpatient and acute care ward.

I would like to talk about recruitment and retention. We have talked a little about health care. I am sure Dr. Fischel is going to highlight problems there also. I would like to talk a little bit more about how that affects the rest of the hospital.

The unemployment rate on Long Island is low. There is a tight labor market, 3.5 to 4 percent, average, I believe, over the last 7 years.

The supply of labor in the health care specialties is even more crucial and more difficult, and we are not competitive salary-wise. However, this does not only apply to health care specialists; recruiting clerical and secretarial help has been very, very difficult for us. Locally, I started about 2 years ago to request special pay consideration for the secretaries and clerical people that work at the facilities. In June of 1987 a package was submitted to the VA Central Office. This cannot be approved without OPM intervention, the Office of the Personnel Management. OPM indicated the problem affected all Federal agencies and would require coordination and cooperation with all agencies. The entire package was resubmitted to that office in June of 1988. There are still problems in that some agencies have not been able to indicate that funds were available to support this request.

These submissions are very important to support our medical care team, the ward secretaries, admissions people, filing people, as well as the other work that secretaries and clerks do for us. I am sure you are going to be hearing comments from the unions regarding how the nursing staff is doing their clerical duties, and I am afraid that is true in some cases.

Mr. **Mrazek**. If you could sum up your statement, please.

Mr. **Manley**. The administrative area, also in middle management, I cannot recruit successfully within the VA in middle management. I would like to point out the significance of the special pay:

We have currently 20 position categories approved for special pay that represent 36 percent of the workforce. What we have pending in VA Central Office right now, if approved, would bring us up to 56 of our employees at special pay; 19 are being developed right now in the medical center. If these were all approved, we would have 61 percent of our employees not on the regular pay scale, but on special pay rates.

Those do create a lot of problems for us.

Mr. **Mrazek**. Mr. Haag?

Thank you, Mr. Manley.

[The prepared statement Mr. Manley appears on p. 65.]

STATEMENT OF GREGORY J. HAAG

Mr. **Haag**. My name is Gregory Haag, Director of Health Care Staff Development and Retention, a new office developed by Dr. Gronvall, as a result of a recruitment and retention task force that he created in 1986. My responsibility is to carry out the recommendations made by this task force, with a very small staff. We are proceeding along that line.

Since my assuming this office in January of this year, I visited a number of VA Medical Centers and talked to the nurses. That does not mean that we are disregarding the other disciplines, but nursing service is the largest, with nearly 35,000 nurses on our roles. This is the core of keeping our beds open. Within these visits, I found that their primary concern is the work load. The work load, not only the nursing work load but, as Mr. Manley indicated, carrying out additional duties that need to be carried out because of shortages in staff in the other areas. This extends not only into the area of administrative, but also some of the other areas such as respiratory therapy and pharmacists. They were very concerned, because their perception is that there may be a shortage of staffing in these other areas, but nursing has to be there. Nursing has to carry out these duties. They are here 24 hours a day. This perception is passed on, unfortunately, to the community, and in many cases, this hampers our ability to recruit.

Many new candidates or applicants apply asking what is the patient-to-nurse ratio. As soon as we tell them that, tell them the truth, generally the conversation ends at that point.

We have initiated a number of areas that we hope will produce some results in our ability to recruit. These areas are: One, in our annual survey, we have just completed the third annual survey. This is a survey where we looked at the positions to find out exactly what the process has been and the experience has been in the preceding year. I am in the process of combining that with some current information that will help us. Instead of looking in the rear-view mirror, we will be able to work on a current basis.

We are also in the process of beginning an enhancement program. We feel that the VA has a rather low profile in terms of competing for these health care workers in the community. Our effort is to improve our profile, improve our image so that we can attract these people. And that goes along with the need for additional salary so we can compete. That's one way we can raise our image.

Our most recent activity in this area is our appearance and our presence at various conventions. In the past, we had taken a pretty conservative stance without any of the glitz that many of the other health care providers have used to recruit. We are improving that, we believe, and experience in the last few visits we made, we feel that we are making progress there.

We also established a nurse task force earlier this year, which has made some significant recommendations as to how we can improve. This task force was made up of field people. We are also pursuing and implementing many of the actions that were passed under P.L. 103-322 which is the Veterans Services Act of 1988. For instance, the Saturday premium pay for registered nurses, tuition reimbursement, child care health care professional scholarship programs, and conversion of occupational therapist. That concludes my presentation.

Mr. **Mrazek**. Thank you Mr. Haag.

Dr. Fischel, please summarize key elements of your testimony. We have your statement for the official record.

[The prepared statement of Mr. Haag appears on p. 83.]

STATEMENT OF EDWARD E. FISCHEL, M.D.

Dr. **Fischel**. I am a physician, the Chief of Staff at the VA Medical Center at Northport, NY since 1983. I am also Associate Dean for Veterans Affairs and Professor of Medicine at the School of Medicine of the State University of New York at Stonybrook.

A little historical perspective might be in order. I came to this facility after it already had undergone a transition from being the largest psychiatric hospital in the VA system to becoming a mixed acute medical, surgical and psychiatric hospital.

In the 1970's, a deinstitutionalization program had been initiated, and there were established eight satellite clinics on Long Island, with about 2,000 veteran patients being cared for. A smaller group could not be out placed and they remained as a long-term component here. This program is probably the most successful one in the Nation, and resulted in very few of the problems which State and county deinstitutionalization programs have experienced. Our patients have been followed regularly. They are growing older, and they have multiple medical disorders which we try to address.

In 1972 a new acute hospital was created to care for the medical and surgical problems of the very large veteran population on Long Island, and also to participate in the educational and research programs in the newly established School of Medicine at Stonybrook.

Various demographic studies have indicated the veteran population on Long Island constitutes the largest concentration of veterans surrounding any single VA hospital in the Nation. So we have learned that a long-term component and an acute care component with some overlap, can work when chronically ill patients require acute care.

The problems peculiar to our location have become manifest over the past 5 years. The cost of public transportation which is diffuse, expensive housing, real estate and State income taxes have all added to the very high cost of services and goods in this area. In the award for special pay that the nurses received in February of 1987, this area, that is Long Island, was recognized as having the highest cost of living on the east coast, comparable to only three other areas in the country. They are all in California. Obviously for most technical and non-technical positions, we compete very poorly with many hospitals, industries and local positions in Government in the area.

Difficulties in recruiting and retaining personnel in this high cost area have been encountered in many clinical and non-clinical support areas. There have been delays which resulted in a negative effect on the work load, quality assurance programs and on employee morale.

In medicine, long delays have occurred in fulfilling the needs of infectious disease specialists, the strategic functions of ETA, evaluation and treatment for emergencies, and admission. We are confronted with new regulations from the New York State Department of Health for the limited hours of the residents and more involvement by supervisors. That has had a pronounced negative effect on the staffing of ETA Physicians interested and capable in this area who are being wooed by numerous hospitals in the State with phenomenally escalating salaries and benefits.

Some other programs for which recruiting has been impossible are, gynecology, with the growing need for care of women veterans, and rehabilitation. In the latter instance, we searched for a Chief with the help of the School of Medicine, but it was unsuccessful a few years ago. The cost of living here was one of the principal factors which resulted in our failure.

We won a designation of a comprehensive rehabilitation center which was awarded competitively from Central Office in 1983. But that program has had to be markedly reduced. There have been additional problems in dermatology, plastic surgery, radiotherapy, otolaryngology, possibly cardiology, and gastroenterology.

We have had two situations develop recently, which illustrate the kind of pressure the Central Office is under, perhaps. In one instance we were told in March to reduce our medical residency component by one, after contractual relationships had already been made several months earlier. This could lead to difficulties—both legal and in terms of credibility for the VA in recruiting residents.

In the midst of these difficulties, the medical center was also confronted by the need to increase our efforts with no increase in resources when the benefits section of the VA decentralized the compensation and pension examinations. Our work load in the program suddenly increased from 30 to 180 examinations per month, with long delays for clinics which are already heavily booked.

Obviously, among the most obvious budgetary constraints of the past several years, is the deterioration of regularly used and basic medical equipment. Existing electrocardiographic machines are outmoded after many years of use, as are many ventilators used in respiratory therapy. For the fiscal year 1989, the reduced budget for replacement and additional equipment, $333,404, is about one-half of our 1987 allocation, and that constitutes a real problem.

Our supply service estimates that many clinical and smaller equipment items require replacement, for a total of about $2.5 million to $3 million. Examining tables, stretchers, wheel chairs, and Gerry chairs, are on this list. Newer types of beds, Clinitron or Kinaire beds are costly but necessary for debilitated patients, who may develop bed sores. These can be prevented or brought to a treatable stage by the newer beds.

In 1982, we used a Cobalt Unit which had been declared excess with the VA Medical Center. The Bronx received a state of the art Linear Accelerator for the treatment of various cancers. We have maintained and refurbished that Cobalt Unit, although it is no longer acceptable for most cancers. Our cancer patients have had to travel the long and very wearing journey into the Bronx on a daily basis for radiotherapy treatments over a course of several weeks. This increases their debility long before any improvement may occur. Recently we have completed a sharing agreement with our affiliated medical school for patient treatment by their Linear Accelerator. Costs are considerable and not readily offset. Cancer has become an unfortunate but frequent occurrence and on-site equipment is needed.

I appreciate this opportunity to present a thumbnail sketch of some of the impacts of the budgetary constraints on our program. However necessary budget cuts may appear to be, they are not without their effects.

Thank you.

[The prepared statement of Dr. Fischel appears on p. 86.]

Mr. **Mrazek**. Thank you, Dr. Fischel.

I'd like to apologize for the fact that clearly there aren't enough seats to accommodate the huge turnout today. But I think what it clearly does is demonstrate just how serious the veterans of Long Island view the conditions at this hospital.

As I am sure you are aware, we have one of the highest concentrations of World War II veterans here in Nassau and Suffolk County. And those of us who served during the Vietnam conflict have one of the highest concentration of veterans of the Vietnam era as well here in Nassau and Suffolk County. I think this turnout is a manifestation of the serious concerns that our veteran population has.

Basically, I think if I can summarize what you are saying as fairly as possible, you are dealing with a budget that has been reduced 20 percent, and that has forced you to dramatically reduce the level of services that can be provided. This reduction has resulted in a lack of basic supplies that are needed in order to provide quality care, and has resulted in a lack of equipment necessary to run a first-class hospital. I think it would seem that the second major element of your testimony relates to the fact that it is very difficult to find and then retain certain types of people who are critical to the success of providing quality medical care, such as clerical people, licensed practical nurses, aides, et cetera.

I know I have met now at numerous meetings, with both veterans who have tried to get quality care here and their families. I know that we are going to be hearing testimony from nurses who work in Building 11, where patients are often very elderly, are incontinent, require showers, three, four, five times a day; the nurses themselves have to, as I understand it, help the patients with the showers simply because you can't find the aides at the salary that is available to be paid for those positions. This prevents the registered nurses from doing what they are supposed to be doing. Is that not correct?

Mr. **Manley**. Yes, sir. As a matter of fact, today, we do have about 50 vacancies in LPN's that we can not recruit. With recently approved special pay, we are just starting now to be able to recruit LPN's.

With respect to the special salary rates we are able to recruit RN's for a year now. As usually happens in hospital, when the nurses are there, there are very few things that they can't do and are willing to do to help the patients. You are accurate in your description.

Mr. **Mrazek**. So you have enough registered nurses in part because you are allowed to pay them through their special pay differential program, which allows you to take into account the fact that it costs a lot more to live here in Nassau and Suffolk County, than other places; is that correct?

Mr. **Manley**. I'd like to emphasize, also, that for nurses, this is not a desirable practice. Their job is to do whatever is necessary to get the patient care done. But I know that they are not always happy doing things that secretaries, nurses' aides and clerks could do if we had them to do it.

Mr. **Mrazek**. I think it is clear, if you are a registered nurse, you have responsibility and you are trained to do certain things that are part of a long period of education. The idea that you would then be doing or performing functions that have nothing to do with that specialty that you have been trained for would obviously be demoralizing.

I would like to briefly talk about, for the record, this pay differential problem. Basically, where you are able to make the extra salaries, you can find and recruit and retain good staff. Where you don't have the pay differential, with licensed practical nurses, you have 50 vacancies. Could you give an example for the record of what an LPN actually does here at the hospital, and why you cannot fill 54 vacancies here in that category.

Mr. **Manley**. On Long Island, there is a large number of hospitals and some very large psychiatric hospitals. The competition for LPN's is very severe. The LPN can do many of the things that the RN can do. However, once again, the LPN usually has knowledge on how to take care of patients' personal needs. They also can help with nursing assistants when it comes to getting patients in and out of the beds, and things of that nature.

I think the special salary rates—they were just approved about 4 or 5 months ago—and we are now borderline in competition with the other facilities out here. But the labor shortage in LPN's is severe on Long Island. We don't have enough for the number of institutions that we have. We have been down between 40 and 50 vacancies in LPN's, I would say, for nearly a year.

What we did about a year-and-a-half or 2 years ago, was to start our own LPN school here. The first group graduated a month ago and are in the process of taking license exams now. We intend to continue with this LPN program. We are doing it in cooperation with BOCES. They are using our facilities, and our employees are being selected competitively to apply for this. That is one way that we are trying to keep our LPN strength up.

Mr. **Mrazek**. Thank you.

Mr. Washko, it is my understanding that in the City of New York, your VA medical facilities in New York City and some other places, this pay differential program is in effect for a lot of job categories, where it is not in effect out here, although the cost of living is just as high. Why is it in effect for those facilities in New York City and not here at the VA Hospital in Northport?

Mr. **Washko**. The VA Hospital in Northport is using the special pay provisions equally well compared with other hospitals in the New York City area, as well as hospitals in the Boston area. They have made numerous special pay requests, and there are still numerous special pay requests pending in our Washington office.

One thing I might point out to you, special pay, while it is a welcome assistance to us, it has some major limitations. One of the major limitations is that it takes a long period of time for a special request to get through. That is because salary surveys have to be done. Sometimes these surveys have to be veered and sent to the Office of Personnel Management. Sometimes it is as long as 5 or 6 months until a salary request can be granted.

Mr. **Mrazek**. If I could interrupt, Mr. Washko, I guess my question is, why do certain identical positions in New York City pay more than those positions do out here?

Mr. **Washko**. I am not aware of any specific examples of that happening. Are there some specific examples.

Mr. **Mrazek**. Mr. Manley, could you respond on that?

Mr. **Manley**. I am unaware on the specifics. I know in the Bronx, Manhattan, and Brooklyn, all three act as a consortium when they go for special salary rates. I believe Northport is in the process of being in the same area; I believe we will be joining them, so we won't be competing with them for some of the same labor market.

Mr. **Mrazek**. If we are not part of this consortium with the other hospitals, we are obviously at a competitive disadvantage in terms of attracting from the little pool of qualified people, people to come here, when they can make more working in those three boroughs of the city.

Mr. **Manley**. I would say we are at a disadvantage with Nassau County, especially, with the boroughs of New York City.

Mr. Mrazek. Before I call on Congressman Downey for some questions, I would briefly like to turn to an issue which has been catastrophic. That concerns the new nursing home unit here at the hospital. Mr. Manley, can you explain whether any patients already at Northport will be transferred to the new unit, and if any patients will be transferred to non-VA facilities when Building 11 is vacated?

Mr. Manley. I can address one patient. We have identified some patients already. We have not made any of these public yet. I am waiting for official word as to whether the nursing home will open June 5th. However, all the patients in Building 11 right now, as far as I know, they either will be going into the nursing home—there may be one or two that are scheduled for a discharge home. We are working with the families on that, of course. Any other patients would be probably housed in Building 9. I don't know of any instance right now that is creating a problem for us.

Mr. Mrazek. I am aware of certain aspects of the situation affecting the nursing home that seem to me rather odd.

For example, it is my understanding that a tunnel was supposed to be created that connected the nursing home unit to the hospital so that food and supplies and patients could be transferred back and forth from the hospital to the nursing home unit, without going outside. That without this tunnel, we are now going to be facing a situation in which we are going to have to truck people back and forth and supplies and food; in fact, meals for the patients. Is this going to take place? If so, why? What can we do to change it?

Mr. Manley. Well, I think it is getting a little late to change now. We hope that some day in the future we may be able to get this tunnel back in. This goes back before I arrived here, but I understand that it was in the original project, the tunnel was to connect with our existing tunnel system.

This was cut out of the project, I believe, at the time I indicated it for review. If you recall, there was a private sector survey, I believe, done many years ago, Peter J. Grace, I believe, was in charge of that. I was in Nashville at the time. I believe this project was one of the ones that went under review when the committee had determined that the construction costs in the VA were much too high. They did hone in on nursing care units. I am relying on memory. I don't know specifically.

I believe this project did go under review. One of the things that was taken out of it was this tunnel. I also think there was some other recreational areas that were taken out of the building, with the recommendation that we should use the dining hall for recreation. When you use the dining hall, you have two sittings in there, three meals a day, you don't have much time to use it as recreation. So there were some things taken out of the project.

Mr. Mrazek. If I can go back to something you testified to, are you talking about the Commissioner J. Peter Grace appointed by President Reagan? Are you suggesting that the Grace Commission actually reviewed the specific construction plans of nursing home units around the country and could have knocked out something as basic as a tunnel to connect the facility to the hospital?

Mr. **Manley**. I don't believe the Grace Commission did. But I believe the agency did the review after the Grace report came out about the construction in the VA. I may be inaccurate. That was my understanding. The Grace Commission, as far as I know, did not review any specific project, but the agency did.

Mr. **Mrazek**. Isn't it fair to assume, if we are going to use trucks to carry meals over to the nursing home unit, and transport these things outside, that it is going to be substantially more expensive.

Mr. **Manley**. I believe that is an accurate statement. We do have some recurring costs now that probably would not have been incurred if we had the tunnel.

Mr. **Mrazek**. I would like to turn to Congressman Downey for his questioning.

Mr. **Downey**. Thank you.

Mr. Washko, I am going to ask you about the emergency supplemental that you referred to before. If my memory serves correct, Congressman Mrazek, Congressman Hochbrueckner, and myself supported that supplemental when it came up for a vote.

Can you tell us what it would mean to you? What would the Northport share of the supplemental be, and what would your region share of this supplemental be if it passed in the next several weeks?

Mr. **Washko**. I have some data on that in my office. I didn't bring that with me. Roughly, as I understand it, there is a supplemental now pending of some $340 million, is that right?

Mr. **Downey**. That is correct.

Mr. **Washko**. As I understand, I will receive approximately one-seventh of that for the Northeast Region after some funding is taken off the top to replenish some of the Washington accounts. I can submit for the record later exactly what we have planned for Northport. I did not bring that data.

Mr. **Downey**. Would you please do that? Would you also describe to the panel, you say you represent 23 other medical centers in the region?

Mr. **Washko**. Yes, sir.

(See p. 64.)

Mr. **Downey**. Have you attended hearings like this with other Members of Congress in those areas.

Mr. **Washko**. No, sir. This is the first.

Mr. **Downey**. Can I ask you about the decision to locate a Linear Accelerator in the Bronx? My understanding is that, as Congressman Mrazek pointed out, we have a extraordinarily high concentration of veterans, not only World War II Veterans, but also veterans of the Vietnam conflict and Korea. Veterans of all conflicts, and that an alarming incidence of cancer has shown up in Northport. Now, given the realities of the concentration of veterans of all conflicts, the incidence of cancers, the fact that the Cobalt Unit was inadequat, can you describe to us the reason the Accelerator was located in the Bronx as opposed to Long Island?

Mr. **Washko**. I'm glad you asked that question, because cancer and care for cancer patients is one of my major preoccupations in the Northeast Region. I have a technical advisory group that has been focusing on the management of cancer care in the northeast for 2 years. As a matter of fact, we have had two conferences here in Northport of all the providers of cancer care in the VA in the Northeast.

Essentially, because of our shortfall in fundings in the VA, we have to, in effect, ration where we put high-tech equipment. The site visit team that has reviewed the Northeast Region has specifically recommended to me that we need to increase the resources for cancer care here in Northport. But the facts are that the budget has not been available to make some additional commitment of the resources here to the Northport area. But we feel that there is a definite need for an increased presence for cancer care here at Northport, and without question there is a need for increased high-tech equipment, Linear Accelerators, particularly, stimulators, things of that sort.

Mr. DOWNEY. Could you give us some time limits on where we may see an acceleration of this sort on Long Island.

Mr. WASHKO. It comes pretty much on the funding level. If we are able to receive some substantially increased funds, we would be able to install some of the needed equipment here.

Mr. DOWNEY. Mr. Washko, I want to make sure you understand. I appreciate your budget situation, what it would be like for somebody from Long Island. If you look at a map, and you are not familiar with the island's by ways, to get from Northport to Lindenhurst, to the Bronx, is a major trip, one of several hours. I have never found the Cross Bronx Expressway, except in the wee hours of the morning, to ever be free of traffic. I implore you, you have the strong support of not only this Congressman, but I think Bob and George as well. We have consistently supported additional funding for the VA. The sooner we can get the Accelerator out here, the better, in terms of service for the people.

Mr. Manley, I want to ask you several questions about the decision on Building 11, if you can give me some, and those who are here, some of the decision-making milestones that went into closing Building 11 as an intermediate care facility.

Then, I want to ask you about when the nursing home opens, one of the allegations that only half the beds will initially be available for patients. If you could give us the dealing component, I would appreciate it.

Mr. MANLEY. Building 11, yes, we have talked about that a long time here at the facility.

About last July was when it first became known that there was a shortfall in fiscal year 1989. It did look as though we would be short about $2.5 million dollars in our budget. Now as I pointed out earlier, there was a substantial loss over the last 4 years. And to make sure that we maintain our quality of care, here, it was decided at that time that we should look at trying to be smaller.

Now, we had several different options. However the most viable one at the time appeared to be and still does to me now, long-term care. Yes, we were adding 120 long-term care beds. I had 160 intermediate medicine beds in the facility now, and it looked as though the easiest way to make the transition without impacting directly on people already in the institution, or scheduled, that in order to be able to make this transition, instead of opening 120 additional beds right now, to open only 40 additional beds. So, that was pretty well communicated, I believe, to the veterans' organizations and to everybody on the Island. I did make the offer and went through Mr. Washko, my supervisor, and the Central Office for review of that plan. I believe everybody did approve of that plan.

The issue of being able to take care of veterans, you are going to be hearing more in some other testimony about what happens. I will be able to make more comments at that time, if you want me to.

Anything else?

Mr. DOWNEY. I want to refer to a letter that we sent to Secretary Derwinski, who was a former House colleague of mine and a personal friend. We were very concerned about the fact that the discharging of patients into nursing home convalescent care would be done with the patient approval. I am especially concerned about spousal impoverishment and that the families' concur in these decisions. Can you assure us that, before the panel and for the record that the concurrence of the family will absolutely be an integral part of the decision to move any patient.

Mr. MANLEY. Yes, we do that quite well now. I think sometimes there are issues, though, that do come up. We are placed in some very difficult situations sometimes when there is not total agreement within the family, what the patient's wishes and families' wishes are. Sometimes the families don't agree among themselves. Sometimes we are placed in very, very difficult situation. I think we always will do whatever we possibly can to support the patients' desires. That is what we feel is our primary responsibility. With a patient who says he or she wants to go home, we will work very hard with the family, if at all possible, to make that happen. I am unaware of any time that we have forced a patient out of the hospital without having a place to go. Now, it has to be also recognized, though, that the patient does have some part in this decision, not just the family.

Mr. DOWNEY. Yes, I understand that.

Dr. Fischel or Mr. Manley, can you tell us whether or not the shortfalls that you have described, whether any veterans have been refused care?

Dr. FISCHEL. I don't think we have turned away veterans who apply for care if they are in a condition that requires care. There are perceived needs by some patients and there are needs that are very difficult for our physicians to satisfy.

I think that by and large, there has been the inability to give care. For example, the need to transport or to send people to other VA hospitals, where there is a lack of technical assistance, high-tech people. We lost our radiotherapy technician and our radiotherapist 3 years ago, and it resulted in quite a drop in our ability to serve veteran patients who needed it.

Mr. MANLEY. There is a case going on right now, I don't know where the funds are coming from yet. We are going to come up with them somehow. We have a patient that we recently transferred to Pittsburgh for a possible liver transplant. Pittsburgh is the only VA in the country that does this.

Mr. DOWNEY. Mr. Washko, recently Secretary Derwinski made a somewhat controversial decision with respect to Agent Orange and financing their claims. Can you give us some of your views with respect to his decision and what impact you believe it might have on veterans in this community?

Mr. **Washko**. The Secretary recently decided to liberalize the provisions under which veterans can receive service-connected compensation and service-connected benefits for Agent Orange. There has been a long controversy mostly between attorneys about what the provisions of the law made available for veterans. I personally applaud his decision. I think that the VA should always be in the position of being a veterans' advocate. I am delighted about his decision and look forward to supporting it and implementing it.

Mr. **Downey**. I would hope and, again, I can only speak for myself, for one who has had the opportunity to see many Vietnam Veterans who are plainly affected with a variety of skin ailments and denied the selected services availability, I think this is a welcome decision, long overdue, and that the implementation of the Secretary's decision should be done with dispatch and compassion, as well.

Mr. **Manley**. I would like to respond to the second part of your question that you asked me awhile back, about the nursing home. We do plan to open a nursing home, as long as it meets the code requirements, which are vague. We probably will open up one-half of the unit to start. We want to iron out any little communication, material management problems that may arise before we open up the second half of it. Within 60 days we will have the entire unit open.

Mr. **Downey**. Thank you.

Mr. **Mrazek**. Thank you, Congressman Downey.

I would like to just explain once again, particularly for people who might have just arrived what the meaning and importance of this hearing actually is.

It is very important to build a record for our colleagues in Congress in order to demonstrate the fact that quality care is not being provided at this hospital due to funding shortfalls, and then be able to, with that record, secure the additional funding that is necessary to provide that care, to find good staff and retain good staff, and to get the kind of high-tech we can, the chemotherapy equipment, the Linear Accelerator, and so on, installed here at the hospital. I can appreciate that there is a lot of anger and frustration in this room from an awful lot of the veterans who are concerned about that, as we are.

But there is no villain in this room, aside from the lack of resources to get the the job done. And what this hearing will accomplish, with the kind of dramatic turnout and support that you are showing by being here, by caring enough to, in some cases I am sure, taking a day off from work to be here with us, we are compiling that record. And I am confident that we are going to be able to use it effectively for a lot of different services.

A couple of points I would like to finalize on the Linear Accelerator before I turn to Congressman Hochbrueckner.

It is my understanding that the life span of something like a Linear Accelerator used for radiation treatment for cancer patients is not significantly long. It might be 10 or 15 years before it is obsolete. Right now the Veterans Administration, of course, thinks in terms of actually purchasing a very expensive piece of equipment like that for a particular hospital, at a cost of millions of dollars.

It is my understanding that the companies that manufacture much of this equipment are having trouble selling it in some cases, due to a tightening of the budget. I am aware of the fact that a corporation which manufactures Linear Accelerators, is willing to lease this equipment on an annual basis. I would like to ask you, Mr. Washko, if we could, in fact, have annual leases, renewable each year based upon future budgets? Would you, in fact, be willing to explore with us the opportunity to lease a Linear Accelerator for Northport without having to find the resources to purchase one, and taking into account that with the technology changing, that it might be cheaper in the long run to lease it rather than to purchase it?

Mr. **Washko**. I would be willing and would be thrilled to explore any liberalization of the law that would allow us to purchase necessary equipment. Let me point out that throughout the Region, I and hospital directors and chiefs of staff discuss almost daily the deteriorating equipment that needs to be replaced. I could cite to you many examples of high-tech equipment that has placed its replacement date in the early 1990s or even in the late 1980s. This is a very high priority for us, and every dime that we can save, we put into the purchase of high-tech equipment, but we really are in serious need for a major additional influx of money so we can reduce the backlog of needed replacement equipment and then purchase some of the additional pieces of equipment, like the Linear Accelerator that is needed for the veterans of Long Island.

Mr. **Mrazek**. I would like to set up a meeting with you to explore the possibility of meeting that requirement for the needed equipment as soon as possible.

Mr. **Washko**. I would be happy to do that.

Mr. **Mrazek**. Congressman Hochbrueckner?

Mr. **Hochbrueckner**. Thank you, Mr. Chairman.

Gentlemen, the lack of Federal administration support for appropriate funding increases is certainly well documented. We understand the impacts when you are short of funds, you are short of equipment, you are short of personnel, you are short of everything. We understand. However, as the three Congressmen from Suffolk County, we receive complaints from our constituents about what you do with what you have. They call usually in the last act of frustration. They call to say, "I have this problem, I have been knocking my head against a stone wall, what can you do to help me?" I think I can also speak for our two colleagues from Nassau County. There are problems. We call here, and we do get responses. But, obviously no system is perfect. For example, I call your attention to Newsday today, the problem of Mr. Raymond Griffiths, a World War II Veteran. This hospital has tried to deposit him on his daughter's lawn on several occasions. These are the kinds of problems that are, yes, not solved in essence totally by money. It is a case of heart.

I don't have a question for you, but what I would like to point out to you that the panel that follows you, through Congressman Mrazek's hard work represents the viewpoint of the people in this audience and in these two counties who have direct problems and concerns.

I thank you for your sensitivity and I hope you can stay and hear firsthand the complaints as represented by the panel.

Mr. **Mrazek**. Mr. Manley, I hope you will provide for the record a list of the equipment that you consider to be necessary for the provision of quality medical care, both diagnostic equipment as well as treatment equipment, for the record. I don't expect you to give us a list of that equipment today, but I would like you to submit it for the record for our evidentiary material.

Mr. **Manley**. Certainly, sir.

(Subsequently, the Director of the Northport, NY, VA Medical Center furnished the following information:)

		Quantity	Unit Price	Total Price
EKG Machine	Medical	9	$8,075.00	$72,675.00
Tray Transport	Dietietics	21	2,281.00	47,901.00
Photocoagulation Unit	Optometry	1	55,000.00	55,000.00
Wheelchairs and Stretchers	A&MMS	40	693.00	27,720.00
Hemodialysis Bedside Station	Medical	4	4,345.00	17,380.00
ECG Digital Acq. Transmitting Cart	Medical	3	11,420.00	34,260.00
Linear Accelerator	Nuclear Medicine	1	1,440,679.00	1,440,679.00
Toshiba digital Gamma Counter	Nuclear Medicine	1	320,000.00	320,000.00
Electron Microscope	Lab	1	285,000.00	285,000.00
ACA700 Analytical Counter	Lab	1	150,000.00	150,000.00
X-Ray Room	Radilogy	1	100,000.00	100,000.00
Physiological Monitoring System	Medical	1	195,683.40	195,683.40
8 Channel Recorder/Monitor	Medical	1	123,000.00	123,000.00
kCoulter Counter Analyzer	Lab	1	95,500.00	95,500.00
Total				$2,964,798.40

Replacement: $1,524,119.40
Additional: $1,440,679.00

Mr. **Mrazek**. I would like to ask a question in regard to the nursing home. Are there provisions being made at the nursing home for women veterans, as well as male veterans?

Mr. **Manley**. Yes, we do have some limited facility available for women. I am a little disappointed that we don't have a little more than we have right now. You have to realize this building has been under construction just about since I have been here, so it has been almost 4 years.

The design probably took 4 or 5 years before that, before it got into the budget. I don't know the history that well. Once the project gets that far along, it is very, very difficult to make the changes within the budget, but I think there are additional things that could have been in there to make the facilities more conducive to the treatment of veterans. We have, do have, private rooms for them. We are in the process of planning, completing plans to make renovations to the building.

Mr. **Mrazek**. With the question of supplies for this hospital, it is my understanding that we will be hearing some testimony from people who work at this hospital with respect to the availability of certain kinds of basic supplies. For example, is it not the policy of the hospital care system that when a nurse is dealing with a patient who might be incontinent, or there are all kinds of fluids and so on, that the nurse wear rubber gloves; is that policy of this hospital?

Mr. **Manley**. Yes, sir, of course.

Mr. **Mrazek**. In Building 11, where you have people who are constantly in need of care, I assume that these gloves are supposed to be used and then disposed of and not used again?

Mr. **Manley**. As far as I know, we do have disposable gloves; yes, sir.

Mr. **Mrazek**. I think we are probably going to hear some testimony that the supply of those gloves has run out on occasion and nurses have been required to use the same gloves with more than one patient. I mean, either you have the security of the staff here at the hospital put at some risk if they don't wear gloves, or conceivably, they are putting a patient at risk because they are using the same gloves over and over again.

But this is, I assume, indicative of budget problems. How do you maintain an inventory of these basic supplies?

Mr. **Manley**. I am sure that would not normally be the case. If it did happen, I can only say that we were unable to fulfill our policy. I think it is indicative of a hospital that has a tight budget. One of the places that you look for is to maybe not have as much of an inventory on your shelf as you possibly should. If, for whatever reason, especially rubber gloves, there was an enormous increase of rubber gloves in this country when the epidemic of AIDS was first known, if there was a back-order of gloves, there might have been a particular occurrence of shortage of the gloves at this time.

I also remember, going back to the Grace Commission, when I was in Nashville we had three gentlemen come to the hospital to look at our use of supplies. They were very, very interested in our supposed big inventory. I don't think any of the gentlemen ever had anything to do with health care or knew the health care industry that well. I also know they made recommendations to our agency, about lowering some inventories. I think, once again, that the inventories that we establish here at the hospital are very necessary. This might be an example of where we fell down, where we didn't have as many on the shelves as we should have.

Mr. **Mrazek**. Thank you, Mr. Manley. I just want to make certain that in the future with budget restorations that that not be a recurrent problem.

Mr. **Manley**. We will do everything we possibly can.

Mr. **Mrazek**. Gentlemen, I want to thank you very much for testifying for us today, helping us build the evidentiary record we will need for our colleagues.

STATEMENT OF THOMAS S. COTTRELL, M.D., EXECUTIVE ASSOCIATE DEAN, SCHOOL OF MEDICINE, STATE UNIVERSITY OF NEW YORK AT STONYBROOK

Dr. **Cottrell**. My name is Thomas S. Cottrell. I serve as the Executive Associate Dean and as a member of the Dean's Committee, which, as you know, has the responsibility for overseeing the educational programs at the medical center.

The medical school has been affiliated with the Medical Center at Northport since 1974. I would like to address the issue of the budget problems from the point of view of an affiliated medical school.

I will read from a letter addressed to the chairman of the Deans Committees in affiliated VA hospitals, from Donald Custis, M.D., Chief Medical Director of the Department of Medicine and Surgery, Veterans Administration, dated 20 October, 1980.

The letter is about the shared responsibility that has characterized the affiliation between medical schools and VA Medical Centers since 1946.

The methods he refers to are the means by which these affiliations have been carried out.

> The methods which have evolved in the ensuing 35 years are well known. Affiliated medical schools have assisted in the recruitment of talented clinicians and investigators who provide the highest obtainable quality of care to veteran patients and, at the same time, serve the medical schools as respected faculty contributors scholarly research and clinical investigation.

Our great concern that the budget problems that are the topic of this hearing, pose a serious threat to the medical care of veterans. These constraints, endanger what I believe to be the very foundation of high quality of care that has been delivered to veterans for the last 43 years, that is the special relationship between academic medicine and the Veterans Administration, now the Department of Veterans Affairs.

The role of the medical schools described in Dr. Custis' letter cannot be carried out if the resources necessary to support their recruiting and sustaining efforts are withdrawn. The ability of the medical schools to identify, recruit, and retain talented clinicians has been the basis of a system of veterans care unequaled anywhere. For instance the delivery of the Linear Accelerator to Northport is only part of the problem. A radiation oncologist that had been recruited refused to serve at the salary level offered by the VA and is now being supplemented by the University. As I am sure you read in the papers, the University is running out of the funds necessary for this kind of subsidy. Talented staff who must be retained will not be easily kept if the salary and resources necessary for their work are lost to budget cuts.

The special relationship of shared responsibility has led scientific exellence as well, as I am sure you all recall a recent Nobel Prize being awarded to a medical school faculty member who was on the staff of a veterans hospital.

The Department of Veterans Affairs has a share in this mutually beneficial arrangement. It is to provide certain resources necessary for the task that the Department and the Medical Schools have undertaken together. If either member of this affiliation falters, the mission will fail and veterans will suffer the consequences.

I am reminded of a couple at a party celebrating their 50th wedding anniversary. They were asked if they ever considered divorce. Almost in unison they answered, "Divorce, never. Murder, maybe, but never divorce."

Well I hope as the affiliation program nears its 50th anniversary, short sighted budget planning and resource limitation do not change the punch line on that story, resulting in harm to American veterans. We cannot do do more with less. If budget constraints are grounds for divorce between academic administration and the Department of Veterans Affairs, the veterans hospitals will not only have abandoned their mission in education and research, they will have severely limited their ability to achieve their goals in the care of the veteran patient.

I thank you.

[The prepared statement of Dr. Cottrell appears on p. 90.]

Mr. **Mrazek**. Thank you Dr. Cottrell.

Are you in essence saying that if these budget problems are not addressed, that the Northport VA Hospital is in danger of losing the support of the Stonybrook Medical School in terms of its accreditation?

Dr. **Cottrell**. I think that the danger is that the support will be severely limited and will interfere with the very basic mission of the hospital.

Mr. **Mrazek**. It is also my understanding, of course, that there is a new veterans' nursing home being constructed near the Stonybrook campus, if I am not mistaken?

Dr. **Cottrell**. It is on the Stonybrook campus. A State sponsored veterans' nursing home, the construction of which is supported by the Department of Veterans Affairs.

Mr. **Mrazek**. I am aware of that.

Now, I assume you are going to be providing medical staff to that nursing home; is that correct?

Dr. **Cottrell**. Yes, the medical school will provide the medical staff and the nursing school the nursing staff.

Mr. **Mrazek**. Do you anticipate any difficulty in continuing to provide medical staff for this hospital, for its new nursing home unit and new nursing home unit at Stonybrook.

Dr. **Cottrell**. We are still in the process of working out those arrangements. Certainly budget limitations will not help in providing that care.

Mr. **Mrazek**. Well, I guess I'm particularly concerned that although we are blessed through the work of an awful lot of people out in this room, Jack Flatly who I see out here, who was one of the long-term leaders in seeing that that unit was built, we want to make sure that with the construction of the new unit at Stonybrook, we are not losing qualified staff at this hospital facility or at the nursing home unit here at Northport.

I am interested in finding out whether you think there is a potential problem that we have to address.

Dr. **Cottrell**. The problem will occur in that there is not specific funds to cover both the nursing home, and geriatric unit.

Mr. **Mrazek**. What about the number of available staff?

Dr. **Cottrell**. In terms of physicians?

Mr. **Mrazek**. In terms of physicians and nurses

Dr. **Cottrell**. We are in the process now of recruiting a geriatrician to head the staff of this nursing home. At this point, we have not been able to find one.

Mr. **Mrazek**. That is a function of the inability to offer an appropriate salary to attract qualified physicians?

Dr. **Cottrell**. That has been part of the problem.

Mr. **Mrazek**. What else is part of the problem?

Dr. **Cottrell**. Geriatricians are in short supply. It is a new specialty.

Mr. **Mrazek**. I would point out something of course well-known to the people in the room. With the aging of our veterans' population, it is very, very important that we do attract geriatricians who are in fact capable of providing the kind of care in as creative a way as possible, using the latest technology. We will look forward to addressing that problem, at least in its function in the budget, to make sure the financial resources are there.

Dr. **Cottrell**. We have the same goals.

Mr. **Mrazek**. Thank you, Doctor.

I will turn to Congressman Downey.

Mr. **Downey**. Doctor, would you tell me what services are not provided at Northport that are provided at Stonybrook? What are the more specific treatments that you offer there that are not offered here?

Dr. **Cottrell**. In summary, we can refer to the radiation therapy program. However, the two Linear Accelerators in the University Hospital are over subscribed. We are building a third one on the grounds of the Brookhaven Lab, covering the patients on the eastern end of the Island. We have no more room to provide for patients.

We have cardiac surgery and cardiology programs at the University that are not provided at the veterans' hospital. We have extensive cancer care beyond radiotherapy. We offer surgery and chemotherapy to cancer patients that is beyond what is provided at the veterans' hospital. We also offer renal transplant services to veteran patients on dialysis at Northport.

Mr. **Downey**. Doctor, can you tell me, with respect to some of the civilian operations at the State University Hospital, whether or not if the Congress of the United States were to mandate, for instance, in the State of New York, assignment for immediate care, what impact that would have on your operations?

Dr. **Cottrell**. I can't tell you in detail. I believe that the major portion of the medical care funding that is provided at the University Hospital by the faculty of the school of medicine is basically tailored to Medicare payments.

Mr. **Downey**. You don't see it as having a major distorting impact?

Dr. **Cottrell**. No. On the other hand, the ability for physicians to treat Medicare patients at lower rates may raise some problems.

Mr. **Downey**. This is really not the time to go into the entire question of medical care that faces our Nation, but clearly the money that you see, the shortages that we see on veterans' hospital care here is part of a broader problem that we see in medicine in general. And the fact is that we are spending 11.6 percent of our gross national product on medical care in this Nation, yet we manage to miss 37 million Americans who don't get any sort of the coverage.

One other question with respect to the types of shortages that you have seen. Does the State University at Stonybrook have a nursing shortage as well?

Dr. **Cottrell**. We have a nursing shortage. It varies directly with the pay scales that we can provide. When the competing hospitals raise their pay, we get a worsening of the shortage. When we raise our pay scales, we ameliorate that.

Mr. **Downey**. Do we have a facility to train nurses at the university?

Dr. **Cottrell**. Yes, there is a nursing school

Mr. **Downey**. Do you know how many are in the graduating class?

Dr. **Cottrell**. There will be 98 bachelor's and 49 master's degrees granted this year.

Mr. **Mrazek**. Congressman Hochbrueckner.

Mr. **Hochbrueckner**. I will be very swift, Mr. Chairman. Obviously we have some witnesses coming up who we are anxious to hear.

I would like to say that I also join the chairman in recognizing Jack Flatly and his contributions to the nursing home at Stonybrook. With the help being provided to veterans at the State level, 16 million at the Federal level, it is an excellent example of a joint State-Federal project. We clearly need it on Long Island.

Dr. Cottrell, can you tell me, is the construction of the nursing home at Stonybrook on schedule, to your knowledge?

Dr. **Cottrell**. The construction is somewhat delayed.

Mr. **Hochbrueckner**. Do you have any idea what the delay is?

Dr. **Cottrell**. I don't know exactly, but it is a number of months behind schedule in terms of construction.

Mr. **Hochbrueckner**. You feel that in light of this delayed schedule that the personnel needed to properly run it will be in place?

Dr. **Cottrell**. We are in the process of recruiting now for the people who we will have to open the home.

Mr. **Hochbrueckner**. Thank you.

Thank you, Mr. Chairman.

Mr. **Mrazek**. Dr. Cottrell, I would just conclude by indicating that it is our commitment to resolve the financial shortfall that you have alluded to, and we will leave the clinical to you. I know that it certainly is in the mutual interest of the medical school at Stonybrook to continue on with this affiliation. Obviously it provides you with your patients to provide care for.

Dr. **Cottrell**. That is absolutely true. The first affiliation the medical school made when it was founded in 1971 was the veterans hospital here in Northport. We are going to continue that, unless we are pushed off the scene.

Mr. **Mrazek**. Thank you, Doctor. We appreciate you coming.

The second panel consists of Mr. Nathaniel Holmone, president, Local 1843, AFGE, and Ms. Georgiana Kachura, national vice president, Region 1, NFFE. Ms. Kachura is also a registered nurse here at the hospital.

Ms. Kachura, would you please start your testimony.

STATEMENTS OF NATHANIEL HOLMONE, PRESIDENT, LOCAL 1843, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, DVA MEDICAL CENTER, NORTHPORT, NY; GEORGIANA KACHURA, MEMBER, NATIONAL FEDERATION OF FEDERAL EMPLOYEES, DVA MEDICAL CENTER, NORTHPORT, NY

STATEMENT OF GEORGIANA KACHURA

Ms. **Kachura**. I am the national vice president of the National Federation of Federal Employees for Region 1. The National Federation for Federal Employees represents 150,000 Federal employees from 40 agencies, of which the VA is one. I appreciate the opportunity to present the views of my union to this committee.

NFFE represents employees of every occupation within the VA both professional and non-professional. Members include registered nurses, LPN's, doctors, dentists, pharmacists, engineers, firemen and police. For the most part these employees have served the VA for a long time, devoting their careers to the VA. The experience and expertise of these employees are without a doubt one of the most valuable resources the VA has.

During the past few years, we have witnessed a problem with the recruitment and retention of these employees. Unfortunately, this comes at a time when there is an increasing aging population and they need greater care from the employees.

We cannot point to just one or two causes for the high attrition and recruitment problems within the agency. We believe that the difficulty stems from a series of crises; proposed and actual budget cuts have severely reduced the resources and damaged morale.

It used to be American veterans received the best care and benefits in the world. A study of the typical hospital like Northport, however, reveals a string of horrors by staff cutbacks. Our veterans are losing out.

The VA needs to increase the funding for the medical system. Without additional resources, VA hospitals will not remain competitive in the private sector in hiring practices of personnel. We believe many VA staff problems are rooted in the VA's outdated and the generally inequitable personnel system. Many VA medical personnel are covered by Title 38 instead of the provisions of Title 5 which do not apply to them. The National Federation of Federal Employees, represent medical staff in veterans hospitals throughout the country. There are staffing problems of varying degrees at different facilities. Whether the hard-to-fill occupation is the registered nurse, pharmacist, or the critical care nurse, there is one factor common to all: The VA's compensation and personnel policies have not given the agencies the resources to remain competitive in its hiring practices.

Veterans entering this particular hospital should expect no more than minimal care. The overworked nursing department is loaded down with the chores of other departments because of cutbacks or the fact that they have been eliminated completely. Nurses have to stop caring for patients in order to find supplies, sort and deliver laundry, intervene in crises, pick up and deliver lab specimens, locate and stock drugs, clean toilets and strip and make beds. When can they possibly care for the patients?

The veterans' health and lives are endangered when nurses must leave their posts to search for medical supplies or equipment because there is no one in those departments to do the work.

My statement, although quite lengthy, goes into care areas that you can look at and read and see what it says.

Many of our veterans lie naked in bed because of our lack of linen, sheets and supplies. In actuality there isn't a lack of these supplies. The problem is that the laundry service has been contracted out, and we do not have enough building management people to remove the dirty linen from the units. It is not that they don't care. It is not that they don't try. They just cannot possibly do all the work that is expected of them. Some of our units have a large supply of dirty linen lying around on the units until someone finds time to remove it. If you don't remove what you have, you will never get enough supplies back.

You should expect a clean and sterile environment when you come into the hospital, but I can tell you that you will not find that at Northport. In many of our outlying buildings where we have chronic patients, urine and feces is exactly what you will smell. In fact the smell is so bad that at times it will gag you. Again, it is not that building management doesn't care, there are just not enough of them to clean the areas. As a result, nursing must stop many times to do it. Building management is not supplied on the evening and night tour and we desperately need these people.

They have been cut very wide and very deep. They have nothing to do with direct care, but they have a definite impact upon the cleanliness of the unit and morale of the staff that must remain there.

The hospital disbanded its psychiatric crisis team because there had been only four crises the year before. The hospital should post a sign to the incoming patients, "No emergencies please."

You may be thinking when you read this report, why are so many GS 9 and 11 level doing the job of the GS 1, 2, 3, 4, and 5? Simply put, there are not enough of these employees. You can't afford to hire them. They won't come to work for you for what you pay. Not when they can go down to the road and do better in the private sector. You can go work for MacDonalds for far more than the VA pays you. If you stay there 2 or 3 years, you can go into management and make a whole heck of a lot more money.

Each of these things have a definite impact upon the ability to retain and recruit. Budget cuts and staff cutbacks have a demoralizing effect on employees, as they become more demoralized the pride in their work work disappears. As pride decreases, so does their ability to perform, so does their work output. The VA system needs the support services that are severely depleted because of substantial cuts. The lack of these services have a direct bearing on recruitment and retention. Some other areas that have had a very definite effect on the ability to recruit and retain have to do with the way in which employees are paid or the bonuses they are promised. I need to say the VA has reneged on a great deal of them.

For example, an operating room nurse is denied night differentials, Sunday differentials, and Saturday differentials when she works these tours. Simply put, it is because management found a loop hole in what Congress voted on as if trying to avoid this payment. We do not believe that Congress meant for these employees to be excluded. As a result these highly specialized employees become more difficult to recruit, especially when they realize how they will be paid. That differential is provided to RN's but is denied to nursing assistants. LPN's and nursing assistants are a very important part of the care team; without them, care could not be provided. It is very unfair to work next to an LPN working just as hard as the nurse yet is denied a differential for the weekend.

COLA's have been denied employees on special salary. We have heard a lot of discussion about special salary. What you didn't hear is that, COLA's were withheld on special salary. The unions objected to this and took this issue to court and won. However, the VA has still not paid the 6 years of back salary. That adds up to a lot of money. Additionally we have not heard about slashing salaries, when the hospital went in for a special salary increase, they in fact and in practice, reconstructed the RN salary so that some those of RN's lost one to five steps. Of the 268 nurses that I represent at Northport, 141 of them lost steps. You gave me a special salary with one hand and took it away with the other, so you didn't give me anything at all. Of the 141 nurses, 37 of them have resigned or retired within 1 year of the reconstruction of their salary. This had a very demoralizing effect. We had to then turn around and recruit 37 RN's. I don't think the VA can afford to do this. This occurred system wide.

Holiday pay for registered nurses working the modified work week have been shorted 2 to 4 hours every single holiday the nurse worked. The union has filed a grievance on this issue. It is directly in contrast to what Congress voted. Uniform allowances are capped at $125, based on a 1966 law. You can't purchase a uniform for $125.

Last year, in recognition of this, Congress went in and raised this to $400 for certain agencies of which the VA was not one. We believe that Federal workers throughout the entire system should receive the same increase in uniform allowance.

Recently the employees of Northport VA were required to take training in OREM's self-care deficit. This required everyone who worked the evening and night tour to be taken off their tour to go onto the day tour. This cost the loss of night differentials for our nurses. I objected, and the RN's got it. I was not able to get it for the LPN's and nursing assistants. It is unfair for them at the low grade and step that they already are at to take a loss. It makes working conditions very tense when some people get paid and some people do not. Lower grade employees cannot afford these type of cutbacks in pay.

Major points that I'm trying to make: One, there are insufficient lower grade employees requiring the professional employees to do work at a higher cost factor to the system.

Two: Congressional actions regarding pay, differentials and benefits are not applied evenly, fairly and are often discriminatly applied. This often hurts the lower-grade employees or the specialty areas like registered nurses the hardest.

Three: Pay to lower grade employees is inadequate and insufficient, and the recruitment of these employees becomes impossible, especially when they can do better elsewhere.

Four: Budget cuts have resulted in gutting staff levels and support services to a level where care is in jeopardy. Work expected of them is unreasonable and work is often incomplete.

Five: Budget cuts have resulted in often lacking supplies and equipment, or inappropriate use of supplies. One of the examples that I gave in my statement was that of gloves. There is just not enough gloves to provide the care that needs to be provided safely.

We did a study just on my unit alone, it comes out that we need 5 boxes of gloves a day, that is 35 boxes a week. We only get 10. That means we have got to wash the gloves out.

Six: The unclean and unwholesomeness of the environment adds to the overburdened system, and fails to convince the employees to remain that the VA cares especially when they can go someplace else to work in a cleaner environment. The essence of the VA system is driving the employees away and is.

I know of a hospital down in Amarillo, Texas which is also building a nursing home. When you read that, you will see that it doesn't sound anymore different than Northport: Insufficient staff, not enough equipment, lack of supplies. How can we build such beautiful brand new nursing homes when we can't take care of what we've got?

One of the points made earlier, Congressman Mrazek, about having to ship the food and supplies by truck, or whatever because we weren't going to have the tunnel and whether this was going to cost more money. What difference does it make how much it cost if you don't have the people to do it? It is not going to get done. How are you going to service this nursing home because you haven't got the staff to take care of what you've got.

What we are saying here is a beautiful multi-million dollar hospital with all its fancy equipment serves no additional purpose than a smaller less equipped facility.

One of the last problems deals with Title 38 issues regarding the Civil Service Reform Act. Recently FLRA decisions have been based on the Colorado Nurses Decision. This has had a very detrimental and negative effect on registered nurses. We must have repeal of that, otherwise the VA's ability to recruit registered nurses is severely affected. Personally I have seen the negative effects it has had on morale, work performance, attitude, recruitment and retention. This is what we've got to go through, and we have to fight it.

Ms. **Kachura**. That is all. Thank you very much.

[The prepared statement of Ms. Kachura appears on p. 92.]

Mr. **Mrazek**. This kind of first-hand testimony is very important, very significant, in terms of our building the case we need to make. I only wish that we had a magic wand to waive to resolve some of these problems, but that is not the way our system works. We are building a complete record with testimony by Nurse Kachura and others to demonstrate the needs that are going to have to be met in the future.

Mr. Holmone, would you please gives us your testimony.

STATEMENT OF NATHANIEL HOLMONE

Mr. **Holmone.** Thank you. My name is Nathaniel Holmone. I am president of Local 1843 of the American Federation of Government Employees. AFGE represents approximately 1,300 of the employees at this Medical Center, in both professional and non-professional bargaining units. As a representative of the employees, we have been directly involved with issues regarding short staffing, retention of employees, pay inequities and recruitment of new employees. All of these factors negatively impact upon our employees, which directly affects those whom we are here to serve, the veteran patient.

The Medical Center has been facing a serious shortage of doctors, nurses, licensed practical nurses, nursing assistants, house keepers, X-ray technicians and other positions. Temporary employees are hired to fill staffing shortages as a stop-gap measure, which fails due to these employees' ineligibility for benefits, low pay and exposure to the short staffing. This results in their quitting if they are not made permanent.

Due to the short staffing, employees are required to work double shifts, work mandatory overtime without consideration of their private and personal lives, having their work load increased greatly, all of which negatively affects the veteran patient. There have been instances where veteran patients have been turned away due to lack of nurses to care for them, doctors doing the work of nurses, technicians so overloaded with work, that the veteran patient spends hours waiting for tests and care.

Our other employees who support the medical team and keep the Medical Center operating, also suffer from this increased work load, unplanned overtime and inequitable salary. Special salary rates for these employees have been pending for over a year, yet, their work increases with no relief in sight. We have had cases where employees' shifts were changed to avoid paying shift differentials, yet we see other things that cost even more money and we wonder what has happened to this? The fact that Washington has cut the VA budget is in effect telling our veterans who have served their country that they no longer matter, which anyone of a reasonable mind would consider to be outrageous. We here at this Medical Center need the necessary funding to care for our deserving veterans and equitable compensation for those involved in their care. Toward that end, we request that you support an increase in funds for this Medical Center.

Thank you very much.

Mr. **Mrazek.** Thank you.

[The prepared statement of Mr. Holmone appears on p. 99.]

Mr. **Mrazek.** I want to thank you both for adding immeasurably to the factual material that we need. Thank you so much.

Our final panel is made up of people who deserve all of our appreciation. They are all not only veterans, they are people who together have volunteered their time, thousands upon thousands of hours of volunteer time. And they are representative of many of the hard working volunteers who have made a difference in the quality of life at this hospital. I would like to call up Mr. Ed Granka, volunteer at the center. He is also a member of the American Legion; Mrs. Yolanda Adkins, a member of the Disabled American Veterans and The American Legion; Felicia Udell, a patient care advocate at the hospital; and Gerard Kahn, a member of the board of directors, Suffolk County Chapter of the Vietnam Veterans of America.

Mr. MRAZEK. Mr. Granka, when you are ready, please go ahead with your testimony.

STATEMENTS OF ED GRANKA, VOLUNTEER, DVA MEDICAL CENTER, NORTHPORT, NY, MEMBER, THE AMERICAN LEGION; FELICIA UDELL, PATIENT CARE ADVOCATE; YOLANDA ADKINS, MEMBER, DISABLED AMERICAN VETERANS, THE AMERICAN LEGION, VOLUNTEER, DVA MEDICAL CENTER, NORTHPORT, NY; GERARD KAHN, MEMBER, BOARD OF DIRECTORS, SUFFOLK COUNTY CHAPTER 11, VIETNAM VETERANS OF AMERICA

STATEMENT OF ED GRANKA

Mr. GRANKA. I am certified by the national organization as a service officer, I do try to help our veterans with many problems and try to direct them to the proper departments with their complaints and help them filling out the necessary forms and so forth.

With the help of the external affairs office, both problems seem to get solved somehow, but I'm going to get to the main part, here. I have a report from The American Legion, which did an on-site survey at this facility this past summer. I will try to incorporate this report with my report.

As you have the written testimony there, it is my purpose to give some background of this facility, namely the medical center and the medical program. The medical center will be faced with a $3.3 million shortfall in its fiscal year 1989 budget. It has taken several actions to insure that quality services continue to be provided to veterans' beneficiaries. To do so, however, the amount of services provided has had to be reduced. While simultaneously activating 80 beds of a new 120 nursing care unit, 80 intermediate medicine beds have been closed. Also, in order to effectively operate a new 10-bed surgical intensive care unit, 8 medical intensive care beds have been closed, or will be.

Additionally, reductions include the restriction of medical care services to non-acute Category B and C veterans and a major reduction in the community contract nursing home care program. Staff reductions and equipment, supply and maintenance shortages will required a further curtailment in services. I won't dwell on that, because you have testimony to that effect already.

It appears for this medical center to operate efficiently and effectively in future years most medical care activity will have to be directed almost exclusively to the mandatory work load. Funding the program in future years is required to meet several medical program objectives, such as development of an inpatient oncology unit, geriatric evaluation unit, an adult day health care program, and construction of 180-bed geropsychiatric facility. Other priority construction requirements include the modernization of the existing psychiatric buildings and consolidation of ambulatory care functions.

Handling of this visit will fall to Mr. Manley. Information related to the medical center's work load operating budget, medical school affiliation and administrative programs are included in the attached appendix. I will try to bring out the high points of it.

As has been testified, the veteran population of Long Island, primarily Suffolk and Nassau County, is one of the most dense veteran concentrations in the country. The medical center is located on the north shore of Long Island and is virtually inaccessible by public transportation. It is vital for the veterans of Long Island, for this VA medical center, to provide a full spectrum of both accute and long-term programs, with a full range of subspecialty care to avoid having to be referred for general subspecialty care to DVA medical centers in the boroughs of New York City. Major east-west transportation and congestion exists on Long Island, and in order to adequately serve its veteran constituents the Northport VA must continue in its role as an academic health care institution.

On page 2, it says "Observations." In short, this medical center has had to enact several program reductions in fiscal year 1989 in order to maintain quality patient services. These measures include reducing 80 intermediate medicine beds, closing 8 medical intensive care beds, closing the community contract nursing home census from 100 to 80 beds and reducing the program's length of contract from 6 months to 2 months. Also program reductions to treatment in Category B and C veterans, employee health visits, collateral visits, and sharing agreements are planned.

In all, approximately 56 full-time employee positions will be reduced in fiscal year 1989 from the previous year's level. A funding short-fall of $3.3 million for fiscal year 1989 is anticipated. Let's hope this projected deficit will be offset by the aforementioned cutbacks.

On the positive side the facility will partially activate a new 120-bed nursing home care unit. It will open a new 10-bed surgical intensive care unit, provided activation funding is received. The current funding shortfall faced by this facility is the result of many years of detrimental budgets and steadily whittling away of funds due to the resource allocation methology model, 1 percent productive reduction, new program activations and a host of national level VA initiatives. In addition to the direct care shortfall of $3.3 million for fiscal year 89, another $8 million dollar shortfall in nonrecurring money accounts was reported. The NRM shortfall includes both new and replacement equipment requirements, physical plant maintenance and supplies.

Compounding the loss of 56 full-time positions due to budget reductions, this medical center, along with all New York City area medical centers, is experiencing severe recruitment and retention problems among its health care employees. It's been estimated this VAMC is about 20 to 25 percent below comparable community pay scales. A local occupational wage scale must be enacted in order to reverse this trend.

The facility has recently completed a pilot facility development plan and through this identification process the primary construction requirements of the VAMC are (1) combined inpatient psychiatry/outpatient facility modernization facility, 30 million; and (2) 180-bed geropsychiatric nursing home care unit, with the installation of a linear accelerator and asbestos removal, which was also identified through this field report.

As you have the written testimony there, Mr. Chairman, I will not go through every paragraph, there, but, primarily with accute clinical services a great amount of the concern was expressed about slow erosion of existing services and staffing.

With the reduction of 80 intermediate service beds, primary care patients are occupying acute care beds; 58 in November 28, 1988. It is believed that budgetary reductions will contribute to the loss of good quality staff. Additionally, through increasing staff, support staff salaries, care would be vastly improved, according to various service chiefs. A few thousand dollars in salary would attract support staff in the areas of ultrasound, and radiation technicians, pharmacists, pharmacy technicians, physical and occupational therapists, nurses, and medical administration personnel.

The projected history in 1989 budget shortfall will have a significant detrimental effect on the delivery of health care services. In order for this facility to activate the new 120-bed nursing care home unit, 80 better immediate medicine beds will have to be closed. This action offsets the action of the nursing home. Still, only 120 of the nursing home beds are scheduled to be activated. The end result, there is no net gain to the veteran population.

Recommendation, also while the new 10-bed surgical intensive care unit is scheduled to open; 8 medical care intensive beds have to be closed to offset the cost of the new unit. Action taken to reduce the community nursing home unit will create a serious reduction in services to veterans eligible for this program. All of the above actions are necessary to balance the projected $3.3 million budgetary shortfall for fiscal year 1989.

In addition to the actions described, a 10-percent reduction in both patient and outpatient work loads will be effected due to restrictions placed on Category B and C veterans. Without receiving a significant increase in funding the actions implemented in fiscal year 1989 cannot be rescinded in fiscal year 1990 or beyond.

In effect the shortages in necessary funding may even lead to greater reduction in services. It is believed hospital management will take the best course of action in dealing with the budget shortfall to make sure quality of service is maintained. The situation in this VA medical center is extremely frustrating and demoralizing.

Other significant problems and challenges facing this facility include the non-competitive wage scales of hospital staff, both health care and assistant employees; the need to consolidate ambulatory care functions under one central authority, meeting its construction requirements; in short and long term, this VA medical center will be seriously challenged to maintain all the recent accomplishments and to continue to foster a positive relationship with its university affiliate.

Mr. Chairman, you have the full report ofour national survey which shows that most programs that were spoken about before, have been implemented. I would like to close with my findings.

Suffolk County organization of The American Legion is appreciative of this opportunity to express its concerns regarding inadequate funding problems of this facility and the medical centers nationwide. We do have a problem here, and at the other 171 VA medical centers. I'm concerned about the 171, because one day it might move on the other kind, and we don't want any problem over there.

The main problem here at the Northport VA is the closing of Building 11. With the transfer of 75 to 100 patients to the new 120 nursing home, in addition to some patients from Building 9 and Building 200, also 100 percent service-connected veterans in the private contract nursing homes will be asked if they would care to be moved to the new homes. For many, this is not home. In reality, it is not a 120 bed gain for veterans, at the most the gain could be about 30, and not the 120 bed gain we were led to believe from the start; and the reason for this is veterans that were placed in private contract nursing homes had a maximum stay of 6 months, and a bed space of 120 veterans. Well, that's not the case again. Maximum stay is 3 months, down from 180 days and bed space 80 veterans down from 120. Reason? Funding, again.

When veterans are placed in the private contract nursing home, the VA picks up the stay. If the veterans are penniless what happens? There is nothing a veteran can do in 90 days even with the social worker assisting. It takes 90 days for the wheels of Medicaid to work. To get the Department of Veterans Benefits to process claims of veterans and family in questions for benefits for veterans eligible is a joke. A waiting period of 6 months to 9 months to process the claim is the norm.

Mr. Chairman, when the new nursing home was under construction, Central Office and those responsible knew that Building 11 would be closed long before the new home was completed. Plain logic, Building 11 should not be closed. We all know the problem, again, funding. The Northport VA Medical Center is $3.3 million short for this fiscal year 1989. Central Office knows this. They also know the need for this facility. I believe Mr. Manley has presented his problems to them, but it seems to go unheeded.

Now we have another problem. I believe when they devised the means test for hospital health care for veterans, putting them in category A, B, and C, that this was a law, Public Law 99-272; well, such is not the case. Most VA medical centers are not honoring this law, and in a recent survey, 80 percent by our recent survey, showed that. We would like to know what good is Public Law 99-272 if all directors of 172 medical centers did this? The reason is funding. This medical center is honoring B and C veterans, that is the price we pay to close Building 11. Again, lack of funds.

In Building 200, there is a surgical unit closed. I questioned the closing and did receive an answer. By closing this unit they still had an occupancy of 86 percent. I wonder though if, in the following weeks there was a need for veterans to be admitted to the unit, would it remain closed? Nationwide, we have 13,000 beds empty. I wonder if additional funds were available, could these empty beds be utilized for some type of nursing care or relaxing the rules for eligibility.

Over the years I have seen many benefits and programs eliminated. To name a few, last year a veteran rated 30 percent service connected was eligible for extra benefits; well, that is changed. It is now 50 percent or over. It scares me to think when they start trimming the budget for the VA it will be 60, 70, and 80 percent, and before long it will be 100 percent service-connected only. The beneficiary travel pay is another item, it has been partially restored and taken back from restored. It is down to a $6 deductible and $18 cap. We believe that if a service-connected veteran came for that particular ailment, he should be fully reimbursed.

The erosion of benefits, several years ago, a nonservice-connected veteran who passes away, his family at one time did receive $150; well, several years ago they did away with that. It seems a veteran is not worth $150. Service- connected veterans, so far, receive $300.

About that travel pay, it does help some veterans financially. And I have to put this one in, cheap shot as it is, a veteran, as an outpatient on medication, was given a refill slip with a self-addressed envelope, stamped with the U.S. postal logo. Well, no more. This program in terms of man hours, cost the same with or without the free postage. We have to put another postage on there. Another way to get the veterans to pay.

In 10 years the percentage of total Federal benefits and service was 4.4 percent. Since there has been a decrease, down to 2.6, and it gets lower. The past 10 years the amount allocated for veterans has increased from $20 billion, which equates to a mere 45 percent increase, while all Federal spending during the same period has risen from $419 billion to $1.1 trillion, a 124 percent increase. The fastest growing area of the VA budget is health care and that has been tightly controlled. Ten years ago the health care system operated on an annual cost of $5.2 billion, and the veterans' health care system cost this year $10.6 billion, which represents 104 percent increase. Now, over the same period, Medicare spending jumped from $26 billion to $86 billion, an increase of 235 percent. In comparison, veterans' programs have been a model of fiscal restraint. The Department of Veterans Affairs Medical Care System increased in its inpatient and outpatient treatment since 1979 from 18 million to 24 million visits per year, and in each of those years they have cut the VA budget. I would say the VA system is very efficient; workers are very loyal. How much can they lower the funding for the veterans workforce in the system. Help is needed badly in the ETA area, doctors especially, and with nurses around here, it seems there is a shortage.

I also find that medical appointments are rescheduled and they are spaced further apart, and at that rate, they can cut your visit from 3 months to 6 months or more. Whether this is a cost-saving plan, I do not know. There are large waiting lines, and as a rule there is but one secretary to handle the phone, handle the folders, and to make the clinical appointments.

The Civil Service Commission improved and recommended an across-the-board raise of 25 percent, but the VA personnel at the Northport Medical Center never did receive such.

In fiscal year 1988, for the first time since 1981 Congress passed and the President signed a free standing foreign aid bill, Public Law 100–461, a total of $14.29 billion in various foreign assistance is allocated for fiscal year 1989. I'll not name them all, but they total $14.29 billion. I realize there is a little politics involved with the above items; 172 medical centers, VA medical centers are facing $1.5 billion shortfall for fiscal year 1990. This medical center is faced with a $3.3 million shortfall for fiscal year 1989, and yet we can not find money for veterans that are in need of hospital health care.

Our World War II veterans and Korean vets are getting old. With this aging population, I cannot understand the closing of Building 11 and the closing of the surgical unit. As we are getting older, more health problems develop. We do not get healthier, unfortunately. The veteran cannot depend upon his spouse for physical help, so what to do? Mr. Chairman, how can we tell these veterans we do not have qualified hospital health care. World War II Veterans put anywhere from 3 to 5 years of their lives in the service of their country, 36 months of overseas duty, a good percentage of that seeing combat. I know that in the audience there are many veterans that experienced combat. I am also one, along with my buddies out here, that endured these hardships.

We who were in the Infantry were called "dog faces"; it took many years to find out why. Did you ever see a dog take his bone and go in the yard and bury it with his two paws? Well, we did it with a pick and shovel that we had in our bags. Foxholes for cover, to cat nap or whenever we had to move up. For food we had C-rations, especially in the extreme northern part of Italy; we had to scrape our food from the can that was half frozen and slushy. How a human can endure this is beyond me. We gave the best years of our lives, and now, 44 years later, for many it is the worst years of our lives. To say we don't have the funds for your health care needs, it is a shame.

We paid for it and many are still paying.

Mr. Chairman, members of the subcommittee, we veterans are tired; tired of being stepped on, tired of being pushed aside; and we are tired of living in fear, wondering whether the programs will be cut, will it affect me? Tired of promises that are broken. But I assure you we will never get tired of fighting for what was promised to us.

[The prepared statement of Mr. Granka appears on p. 101.]

Mr. **Mrazek**. Thank you.

We have another veteran of World War II, who also served in Italy. That is Yolanda Adkins,

Please come forward.

STATEMENT OF MRS. YOLANDA ADKINS

Mrs. **Adkins**. Mr. Mrazek, fellow veterans and friends. My name is Yolanda Adkins, and I am a veteran. I guess I am supposed to say it is a pleasure to be here, but under the circumstances it really isn't. However, I am delighted to have the opportunity to address this audience.

You are aware of the problems facing veterans today all across the country. What is the answer? Money. I served overseas in Africa and the invasion of Italy. I saw how some of our men were brought into the hospitals. Some so unrecognizably mangled, begging to be killed because they couldn't stand the pain. I am outraged when I think about them being denied the medical care they were promised. We know there is a lack of adequate funds to provide satisfactory health care for our veterans. Millions of dollars are sent all over the world, even though we know that much is wasted and some going into the hands of corrupt public officials, but there never is an extra dollar for veterans.

The VA today accounts for only a small part of the Federal Government's medical expenditures. When we went off to war, the majority of us volunteers, we made a commitment and we kept that commitment. Our Government made us a commitment, also, which over the years they have been trying to abolish.

We are not against elected officials getting a reasonable pay raise, but should they not bite the bullet the way they keep telling us to do? If they spent less time on speaking appointments and more time on the budget, I am sure they could come up with an equitable solution to this crisis. We are told that we must pay higher salaries if we want to attract the more capable people for public office. I agree with that, but doesn't that apply to the veterans' hospitals as well?

It is getting more difficult to recruit and retain physicians and nurses for our VA hospitals because of the low pay scale.

When a physician leaves us, it is usually because they can earn more money in the private sector or some other system.

We have the most sophisticated machines in this hospital, but they aren't doing us any good, because we don't have the technicians and qualified people to run them. If a machine becomes inoperable it could take days or weeks before it is repaired, because there is no money allowed for such emergencies at that time.

There are all kinds of problems all over the hospital. And the ETA is no exception. The worst problem is being short staffed, therefore creating many long hours of waiting for many patients. When a doctor goes on vacation or is out sick, there is no coverage. Right now, our doctor in ETA is diligently trying to update and make the ETA more efficient. No matter what recommendation or suggestions she offers, she is told she can't implement them because there is no money for such programs. She has recently put into effect the triage program, which means that patients with life-threatening problems are seen first. This is great for those particular patients. However, the other patients can wait for hours. The ETA not only serves the outpatients, but also about ten other outlying units when emergencies arise.

Triage requires additional staff, but they have not been allowed any. If you get stuck after 4 p.m., you may as well go home. God forbid you should get sick on a weekend, there is only one doctor to take care of the ETA and whatever happens on the units. If the ETA staff has to answer emergencies within the hospital, what happens if a critical patient is brought into ETA at the same time? So take advice from one who knows, don't get sick on a weekend.

It has only been in recent years that women veterans have received any consideration in the VA system, and the little that was given was given reluctantly. Now that women veterans have finally been able to take advantage of the health care system, it is being jeopardized by unmerciful financial cuts from our Government.

On one side, medical centers are told to outreach to women veterans, but funds are not provided for the women they attract. Further, we had to put up with the resentment and attitudes of the doctors, refusal to stock medications for us in the pharmacy, et cetera.

With the formation of the Women Veteran's Advisory Committee, which I co-chair here in Northport, we have been able to see the light at the end of the tunnel, so to speak. We also have an advocate of the month, where a member of the committee visits all the women veterans admitted to the hospital, and each month a different member is the advocate. We have been able to make known our needs. The response has been surprising. While there is no provision yet made for mammagrams in this hospital, and there is still no gynecologist at this medical center, these services must be contracted out, we do get most of the medications we need.

There have been other changes for the better, and another plus for the women veterans is the Women's Health Clinic. We have one of the most dedicated women doctors in this hospital; the amount of women using the VA hospital has increased a great deal, with over 2,500 in data base and over 450 admitted since August of 1985. Just since last October, there have been over 700 women patients on active rolls. Many do not come because of the lack of a certified gynecologist, and I know there would be many more if we had one. Even though women have been turned off in the past, I hope to see more of an increase in the VA system now that we are finally getting recognition.

There is one other area that I would like to mention, before closing, and that is the record room. That is my baby, because that is where I do most of my volunteering. Those people are overworked, understaffed and underpaid, to say the least. Because of the tremendous amount of records kept there, we must use more than one room, which makes the situation more difficult because you have to run back and forth. So a great deal of time is wasted. Records can't be kept in order because of the lack of room, plus the shortage of personnel.

I have seen reports from last year that haven't been put into the patient's folder as recently as the last few weeks. Reports get lost or misfiled because there isn't anyplace else to put them. We were told last year that the whole area was going to be changed and everything would be in one large room. There would be a place for everything and everything would have a place. Yes, there were changes made, several pieces of furniture have been moved around. But there is simply not enough room to make the necessary improvements.

We can not allow our health care system to be destroyed. The VA has been a patsy of Congress for too long. This time, our Government must listen to us, and we must demand that they restore money that they have taken away from us. Without it, we cannot hope to attract physicians, nurses and other vital clinical and clerical personnel necessary to operate our hospital successfully and efficiently, and in order to accomplish this, we will not give up.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Adkins appears on p. 104.]

Mr. **Mrazek**. That is absolutely magnificent testimony and very helpful to us.

I would point out that in my view, the Veterans' Administration clearly has not received the funding commitment that it needs from Congress. But it is important to point out that the Grace Commission was not appointed by Congress, it was appointed by the President. The Grace Commission recommended the absolute dismantling of the veterans' care hospital system, and we fought that in Congress, and we were able to defeat those recommendations by the administration. I think we've turned the corner on that.

STATEMENT OF MS. FELICIA UDELL

Ms. UDELL. Good morning, and welcome to Long Island on behalf of the patients and families of patients at the VA Medical Center in Northport.

My name is Felicia Pasculli Udell; I live in Suffolk County. I am married and have three children, own a business and am a Vice Chairman of Long Island Alzheimer's Foundation and a member of Concerned Families of Patients at the Northport VA Medical Center. I give you this background not to impress with you with my versatility, but rather to point out to you that I am a responsible, hard working, caring member of my community who resents the fact that I have had hours upon hours taken away from caring for my family, father, and business because I have had to fight for what my father and others like him can no longer fight for, their rights as veterans of this country.

The more families I speak to, the more I realize that this is a common predicament among families concerned with this VA medical center. The sword of Damocles is hanging over everyone's head. Rather than find solutions, we come up with painful questions. Why is the budget being cut at a time when we have an aging veterans population that are hopefully representatives of the last global confrontation we will suffer? Why, especially at Northport, a center serving an area of the Nation with the highest density of World War II and Vietnam veterans? Why is the medical center choosing to cut the services of the oldest and the weakest? Is this the same Government that set the example for civil rights and the rights of the disabled? What message is being sent regarding treatment of the elderly? The veterans population reflects the population at charge.

Does increased longevity mean living long enough to see promises broken? Let me tell you about Jimmy Giles. Jimmy Giles is a 91-year-old World War I veteran. He was a resident at Building 11 of this medical center. Back in March of this year a decision was made to begin discharging patients from Building 11 ostensibly due to budget cuts and probably to avoid these patients' transfer to the new nursing home. Jimmy Giles, a man with one of the supposedly highest priorities at the medical center, was given 3 days notice and moved to a nursing home against his will. He is blind, has cancer, and has a tube, but as Barbara Woodrich has stated, he's stable. Well, so is that poor woman who was beaten in Central Park weeks ago, and so is a person sometimes after a gunshot wound, but that does not mean that they should be moved. He is desperately unhappy where he is, and wants to leave as be soon as possible. Why isn't there an independent forum, family counsel or ombudsman that patients and their families can seek relief from, rather than just patient representatives that work for the center and often don't know enough of the rules themselves.

Exhibiting behavior common among victims who blame themselves for the crime, many veterans blame themselves and other veterans for not fighting the cuts that have taken place over the last several years. Why should they feel this way? Why should a person who served his or her country honorably, sometimes under the most horrendous conditions, have to fight for what was promised? Who would have imagined a time when the Government breaks its own laws regarding those promises? When a Government legally mandated to provide approximately 90,000 beds nationwide, provides money for 55,000? What was the purpose of conferring cabinet status to Veterans Affairs? Was it to provide a diversion for the ambush? If so, it succeeded. We are determined to win the war. Don't dismantle the system at a time when it is so needed.

Let me tell you about my father, Patsy Pasculli. He is a disabled World War II veteran, suffering from Alzheimer's Disease and a host of other ailments. He is in Building 11 at this medical center. Anytime my father sought medical treatment or consultations during my lifetime, it was at a VA medical center. I truly believe he felt better understood and better cared for at the VA facilities. He came to this facility as an acute care patient and he was eventually transferred to an intermediate care unit, which is a euphemism since there have been patients in this unit and other units for as long as 40, 12 and 9 years. In between his acute care stay and present stay, he was transferred to a contract nursing home, where he developed pneumonia and blood poisoning, and almost died. Fortunately, he recovered and was transferred back here. In addition to the care from the nurses and aides here, I believe the patients feel consciously and subconsciously a level of dignity and self-esteem that they would not feel in an outside nursing home. Apparently the administration of this country and of this center does not understand this perspective at all. Why are they so belligerent towards the patient and the families. Since when did the veteran become the enemy?

Let me tell you about Ray Griffiths and his family. The story about Ray was in today's *Newsday*. Ray is an elderly World War II veteran suffering from Alzheimer's Disease. Ray's family had been trying to get him admitted to the medical center for over a year without any success. Last August, 1988, Ray was admitted to the medical center for a hernia operation. At the time, a resident physician informed his family that the hernia was so large that it was intruding into his bowel. Ten days later, the hospital wanted to discharge Ray back to his family without having done the surgery. No explanation was given. The family informed the hospital that they would not take him back because they were unable to care for him.

Ray and his wife had been living with his daughter's family in an effort to deal with his condition. He had almost burned the house down three times and had wandered away many times. The hospital was aware of this since the Griffiths family had presented them with extensive medical documentation when Ray was admitted for the surgery. So what did the hospital do? For 5 days they tried to leave Ray at the doorstep of his daughters's house. Although Ray's daughter had shown the hospital a copy of the deed to her house, proving it was her's and her husband's, they once again brought him to his daughters's house, only this time it was alone in a taxi, in spite of the fact that they were cognizant of his mental condition. Fortunately, the taxi driver was a humane person who personally returned him to the hospital. We also now know that a social worker at the medical center was instructed to hire a locksmith to break into Ray's daughter's house and to leave Ray inside.

Why are they being treated this way? Why is another family with a father in the hospice, who apparently isn't dying within the 6 months limit, being hassled about moving their father, rather than concentrating on the fact that he is dying? Why hasn't Mr. Manley who by his own admission says that at least 40 percent of the population of this medical center suffer from some degree of dementia have a unit to deal with it? Why at a time when the hospital's own statistics prove the need for chronic care beds and the underutilization of acute care and rehabilitation units, has the focus of the new nursing home been changed to geriatric rehabilitation and clinically complex cases?

I am sorry, I'm still not clear in spite of all the questions that have been asked as to what the nature of the new home is all about. Why has the focus of the home been changed from long-term care to 90-day stays, which is another issue that really wasn't addressed, at the same time the hospital has cut the time it will pay in a contract nursing home from 6 months to 3 months? Are they determined to pauperize as many families as possible? Getting back to the new nursing home, who made the decision to change the nature of the nursing home? How could this policy change be made in light of veterans needs on Long Island? How could it be made in light of the Secretary Derwinski's comments recently. In response to a question on saving money for health care purposes by closing down underutilized VA hospitals, never mind in an area as densely populated as ours, Secretary Derwinski stated the follow: "It won't be the issue of closing. I don't believe we will have to close any facility. What we may do is readjust their mission from a total hospital entity perhaps to more long-term health care, more of a veterans, senior veterans housing entity, rather than a full-blown hospital."

What are the criteria for admission into the nursing home, into the immediate care units, into the hospice? Why has the administration of this hospital consistently failed to answer these questions? Are there Federal guidelines to be followed? Are they being followed? The Administration has talked of getting higher reimbursement for certain patients as opposed to others, is this so? If it is so, how does the reimbursement work? Is is it a money system? Is it a point system? Does the VA get reimbursement from private agencies or governmental agencies? If not, why not? Many families here have expressed a desire to contribute to the system. Keeping people ignorant of the system does not benefit the system.

The budget cuts must be restored. They have resulted in hardships above and beyond those perpetrated by the administration of this medical center. Patients never have enough socks, pajamas, linens, or working wheel chairs. There have been horror stories of the shortages occurring during surgery and lack of vital medication. This county, which probably has the most Vietnam veterans in the country, desperately needs a post-traumatic stress disorder clinic. You must restore the cuts. You have a moral obligation to do so, or perhaps one day you will give a war and no one will come.

I have asked you many questions on behalf of many families and patients at this center. Hopefully, you received some insight into the frustrating dilemmas we have experienced. We would like to know how much time will pass before these questions are answered truthfully and definitively. Once again, thank you for coming to Northport.

Mr. **Mrazek**. Thank, Mrs. Udell.

[The prepared statement of Felicia Udell appears on p. 107.]

Mr. Kahn?

STATEMENT OF GERARD KAHN

Mr. **Kahn**. Mr. Mrazek, Congressmen, fellow veterans. My name is Jerry Kahn, and I served in Vietnam from May of 1967 to January of 1969 when I was wounded in action and retired and honorably discharged from the U.S. Army. I am a 60 percent service-connected veteran who used these facilities up until the last year. I spent a year in counseling at the Long Island Vet Center for readjustment problems. I was a volunteer for a number of years as a co-facilitator in groups for veterans coping with similar problems. Currently, I am a member of the Board of Directors of the Vietnam Veterans of America, Suffolk County, Chapter 111.

According to the Triangle Research Study 70 percent of all veterans who served during the Vietnam era enlisted. For many of us it was with the understanding that we were entering into a contract that our fathers and uncles had before us, to serve our Nation in time of war honorably, and in return the Veterans' Administration would provide for our health care. Now our Government is telling us that providing for these needs is too expensive. Perhaps with our troop build up in Panama, Congress should start thinking of the cost of this generation's needs. In DVA we have often wondered if Congress should put a warning on C-rations similar to the Surgeon Generals warning on cigarettes, "Caution, the killing of people on a daily basis and the death of comrades you love can be hazardous to your mental health, and your Government cannot afford it."

We would like to make it clear at the outset, that our chapter is totally dedicated to quality heatlh care for our older brothers and sisters as well as the younger veterans coming up behind us. Today we are here for the specific needs of DVA Northport in carrying out this mission.

This country allowed both World War II and Korean vets devastated by the rigors of combat to suffer in isolation, or turn to alcohol as a means of dealing with war experiences. Growing up, we can now remember how cruel we were, repeating grown-up talk, "She has shell shock," or "He couldn't hack it." I remember how I always wondered why my father wouldn't take my family to the beach. As children, we were only concerned with our own wants and needs. Now, however, after my own experience with war, and the trauma that goes with it, I understand that if my experience had been island hopping in the Pacific and I associated all beaches with death, perhaps I wouldn't go to a beach either.

Vietnam veterans do not feel that PTSD is a weakness, and that in fact it is a logical reaction to unnatural events. Many veterans are now learning to cope with the emotional problems; however, much more needs to be done. A stress ward at DVA Northport would go a long way to addressing this problem not only for Vietnam Vets, but World War II, Korean vets and vets of the future. In fact, current studies indicate, 30 percent of active PTSD cases in treatment are, in fact, World War II and Korean vets.

To further make our point, I am employed by New York State Department of Labor, in the disabled veterans outreach program. I can still remember my first placement. A Korean combat vet, who had every classic symptom of PTSD, and a history of low-wage positions as long as my arm. While outstationed at the Long Island Vet Center I interviewed a Vietnam vet who spent 23 months in Vietnam as a crew chief on a Medivac helicopter. Upon his return home he spent 5 years as a smoke jumper with the Forest Service. Again, every classic symptom of PTSD While going through the VAMC Northport with the New York State Temporary Commission to study the readjustment problems of the Vietnam veterans, I found out that the vet had been referred to the hospital for in-patient care for PTSD and was turned away because there was no program to treat this problem at this facility.

I would like to say now that the only facility that handles the entire downstate project is in Monroe, NY, which is a 13-bed facility, from approximately 237,000 Vietnam veterans, not counting, Korean veterans and World War II veterans. Studies have found the rise of PTSD in World War II and Korean vets is on the rise. Family responsibilities, retiring from jobs, and reunions, they are now experiencing more and more problems with this. Thirteen beds for this population is totally inadequate.

I am not sure what price has been put on life by the Federal Government, but I wonder how long can we afford to throw away the lives of those veterans who gave of their future so this country can enjoy the peace and prosperity it has today, helped to live the life he thought today, would be worth it. We need a stress ward at DVA Northport. Not tomorrow, but today.

What is needed to insure this quality health care at DVA Northport is quality staff with a quality support network behind them to accomplish this mission. The present classification and salary structure makes this mission seem impossible.

To explore the job market on Long Island and to get reasonable salary ranges you need only look at the help-wanted sections in *Newsday* to be more than convinced of the inequity of the DVA system. What is classified by the DVA as a secretary in their system rates a GS-5 or $15,738 to $20,463 or step 10 which usually takes 20 years to achieve.

The papers, on the other hand, lists positions for $18,000 to $25,000 range to start. Clerk positions listed in newspapers range from $14,560 to $17,000. The Federal Government lists qualifications as a GS-1 or 3: A GS-1 never reaches this salary range, while it takes a GS-3 to step 6 to reach the lower scale and never reach the upper scale. Many people think that raising salaries is expensive. However, when you stop to think about the M.D.'s; RN's and the other health care professionals doing this work and being taken away from their own assignments, what is the cost then to veterans and to DVA's budget?

In rehab medicine, therapists with masters degrees are only classified for GS-9 positions, or $29,000 to $36,000 a year, while other areas they range from $40,000 to $50,000. We must also look at the salary range of personnel at DVA hospitals that range from GS-7 to GS-9. When compared to other personnel Departments in the private sector, they do not fare too well. The list could go on, but I'm sure at this point, we have gotten our message across.

In 1987, DVA Northport put in for a special increase for grades 1 through 6; that they are still waiting on. DVA Northport needs the immediate intervention of Congress to grant DVA Northport these special salary rates while they study the long-term effects that substandard salary packages have on quality health care.

I would like to add at this point in time that special salary increases have been granted to New York City for the last 2 years, in Brooklyn, in Manhattan and The Bronx. They were making more money for GS-2 through GS-6 2 years ago, than our current people are making now. This inequity needs to be changed.

I would be remiss in my duties to serve my organization if I did not bring up what has been a constant source of irritation for us. In our written statement we referred to the shortfalls of the personnel section at DVA Northport. One area we did not fully cover was a problem we perceive as of the utmost importance, that is the hiring of veterans. We have been informed that approximately 25 percent of the workforce of the DVA Northport is made up of veterans, and we have also been informed that this is above average for DVA facilities. We appreciate the generosity of the personnel office. We would like to know in what salary classifications and salary ranges by department these people are serving in—not by percentage, but by number. Who would be better able to understand the quality health care needs of veterans than other veterans. This is an idea that has worked well in vet centers and perhaps it's adoption by DVA would serve them well.

Our organization has not commented on the overall view of DVA Northport. During our relations with the hospital, we would like to single out Barbara Woodrick, director of external affairs, Andrea McGrath, Patricia Bucholz, patient representatives Carol Homes, Fran Meida, and the entire staff of external affairs.

In closing I would like to add that quality health care means many things to many people. During the Vietnam war, people who could afford quality health care could exempt themselves from military service. Today, those who served are only asking the same privilege, the means to protect their health and ensure the future. Thank you.

[The prepared statement of Jerry Kahn appears on p. 109.]

Mr. MRAZEK. Thank you very much.

Congressman Downey?

Mr. DOWNEY. I would like to thank the gentleman from Sayville for his fine testimony today. The testimony we received today, Mr. Chairman, is powerful and convincing. I don't know that anybody needed to be convinced, the question is whether or not we can convince others.

You have all hit it one time or another: Mr. Kahn, Mrs. Adkins, Mrs. Udell, the fact is unless more money is forthcoming, there will be more problems.

While it is very difficult to leave this hall, and very frustrating to consider the idea that that money may not be forthcoming, it is simply a question of whether or not those of us who are prepared to vote for more money, and all of us are here, the question is whether or not we can convince our fellow Representatives that they have a responsibility to the veterans of all categories to provide that money. And that means, to a certain degree, that we either cut other programs or we raise revenue.

Now, I am prepared to do a little of both, but the fact is that many people are not. It is up to you, as we leave this hearing, to hold, as I said at the outset, our feet to the fire. The further question that you will have is when we go to other places throughout our congressional districts, whether or not we are prepared to tell them what you have told us, that there are unimaginable horrors that happen here, not because the nurses don't want to work hard, but whether or not this Government is prepared to meet its commitment. The nurse who testified gave us an example of the sort of courage that we see from the people who work here. I hope that it is. I'm prepared to vote that way, and I hope you will hold our voting records accountable on that score.

We are going to make this testimony available to many of our colleagues. This is just an example, as you have pointed out, of one hospital in this condition. It is mirrored throughout the country. Whether it is treatment of stress for Vietnam veterans who have problems that need to be addressed in a unique manner, or nursing home questions for older veterans, both are important to us. The question is whether they will provide the money. I hope they do.

This testimony will help us to educate them to get this money.

Mr. HOCHBRUECKNER. Thank you Mr. Chairman.

The point I would like to make to the four latest witnesses here before us, is that you made your point eloquently. I thought you spoke extraordinarily well on behalf of the hundreds of the people sitting behind you and certainly the thousands of veterans here on Long Island and across the Nation. I want to thank you for your input. You made your points extraordinarily well. I think the administration here, as well as the administration in the region also got the point. So I want to thank you for your presentation today.

Certainly we all recognize that the freedom that we enjoy in this Nation today did not happen accidentally. It happened because the veterans put their lives on the line, their bodies on the line, their futures on the line. We understand, and we thank you.

Without objection, the statements of Congressman Morrison and Congressman Rowland will be inserted into the record. I would also like to thank everyone.

Please, sir, I would like to thank everybody for coming here today. In addition to the very clear message that has been delivered in terms of the amount of funding that is going to be needed to improve the quality of service, some very important specific questions about the administration of the hospital were raised, and they deserve answers. We don't have answers here today to those questions. It would be my hope that at the next hearing we will be able to respond specifically to the questions that have been raised here, in addition to the funding concerns.

I can only tell you that I appreciate the patience most of you have displayed at this hearing. It is, I think, very important, irrespective of whether we are able to restore overall funding levels, for the entire VA budget, that we are able to provide the resources necessary for our community, for our veterans here on Long Island, here at this hospital. I can pledge to you that on behalf of the other members here today, we will do our best to see that that funding is brought back to this hospital, that this hospital does not become one of the hospitals that is diminished as a result of these funding cutbacks.

Mr. **Mrazek**. This hearing is now concluded.

[Whereupon, the hearing was adjourned.]

APPENDIX

OPENING STATEMENT OF HON. BRUCE A. MORRISON
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
NORTHPORT, NEW YORK
MAY 15, 1989

THIS HEARING OF THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE VETERANS AFFAIRS COMMITTEE OF THE U. S. HOUSE OF REPRESENTATIVES WILL COME TO ORDER.

GOOD MORNING. THE SUBCOMMITTEE IS MEETING HERE TODAY AT THE REQUEST OF CONGRESSMAN BOB MRAZEK. THE CHAIRMAN OF THIS SUBCOMMITTEE AS WELL AS THE FULL COMMITTEE, SONNY MONTGOMERY, SENDS HIS GREETINGS TO ALL OF YOU WHO HAVE COME HERE IN BEHALF OF VETERANS' HEALTH CARE.

OUR COMMITTEE INITIATED SOME DRAMATIC STEPS STARTING ABOUT ONE YEAR AGO TO DOCUMENT THE STATUS OF VETERANS' MEDICAL FACILITIES ACROSS THE NATION. IN TWO SURVEYS AND A NUMBER OF HEARINGS IN WASHINGTON AND OUT IN THE FIELD, WE FOUND THAT HOSPITAL DIRECTORS AND MEDICAL STAFF HAVE STRETCHED FUNDS TO MEET INCREASING COSTS OF DELIVERING CARE AND INCREASING DEMAND FOR SERVICES. OVER THE PAST TEN YEARS, THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL BUDGET HAS REMAINED LEVEL, WHILE THE NUMBER OF INPATIENTS TREATED HAS INCREASED 7 PERCENT, THE NUMBER OF OUTPATIENTS HAS INCREASED 29 PERCENT, AND NURSING HOME PATIENTS HAVE INCREASED BY 63 PERCENT. DURING THIS SAME TIME PERIOD, COMPETITION FOR HEALTH PROFESSIONALS HAS REACHED NEW HEIGHTS. THE VETERANS' HEALTH CARE SYSTEM FINDS ITSELF NEEDING TO PAY MORE IN ORDER TO RECRUIT MANY SPECIALISTS, ESPECIALLY NURSES AS WELL AS PHYSICAL THERAPISTS AND PHARMACISTS.

IN RESPONSE TO OUR COMMITTEE'S RECOMMENDATION, THE HOUSE OF REPRESENTATIVES APPROVED AN AMENDMENT TO THE CONCURRENT BUDGET RESOLUTION REPORTED BY THE COMMITTEE ON THE BUDGET. THE AMENDMENT PROVIDED AN INCREASE OF $216 MILLION IN BUDGET AUTHORITY AND $179 MILLION IN OUTLAYS FOR A TOTAL FISCAL YEAR 1990 BUDGET OF $31.225 BILLION IN BUDGET AUTHORITY AND $29.975 BILLION IN OUTLAYS. IT WAS THE ONLY INCREASE IN FUNDING LEVELS ABOVE THE LEVELS RECOMMENDED BY THE COMMITTEE ON THE BUDGET FOR THE ENTIRE GOVERNMENT AND I AM PLEASED THAT WE WERE ABLE TO ACCOMPLISH THIS. FUNDING FOR DISCRETIONARY PROGRAMS IS $900 MILLION HIGHER THAN THE LEVEL PROPOSED BY THE ADMINISTRATION; MOST OF THIS ADDITIONAL FUNDING IS TARGETED FOR VETERANS' MEDICAL CARE.

WHILE THE HOUSE BUDGET RESOLUTION WOULD ALLOW UP TO $11.6 BILLION FOR VETERANS' MEDICAL CARE, MORE IS NEEDED TO RESTORE VETERANS' HEALTH CARE TO ADEQUATE LEVELS. THEREFORE, OUR COMMITTEE HAS RECOMMENDED A $432 MILLION SUPPLEMENTAL APPROPRIATION FOR THE CURRENT FISCAL YEAR AND IT LOOKS AS THOUGH WE ARE GOING TO GET ABOUT $340 MILLION.

AS A RESULT, WE MAY HAVE TO CONSIDER OTHER ACTIONS. FOR EXAMPLE, IN MY OWN STATE OF CONNECTICUT, THE TWO DEPARTMENT OF VETERANS AFFAIRS HOSPITALS HAVE THEMSELVES WORKED OUT A CONSOLIDATION OF SERVICES. BY JOINING TOGETHER AND REINFORCING EACH OTHER, THEY CAN OBTAIN PRODUCTIVITY AND PROVIDE MORE COMPREHENSIVE SERVICES TO VETERANS THAN WOULD BE POSSIBLE SEPARATELY.

TODAY, WE WILL RECEIVE TESTIMONY ON HOW NORTHPORT IS DEALING WITH THE RESOURCE CONSTRAINTS THAT EXIST. WE ARE JOINED BY YOUR OWN VERY ABLE CONGRESSMAN, BOB MRAZEK, AS WELL AS CONGRESSMEN TOM DOWNEY AND GEORGE HOCHBRUECKNER. CONGRESSMAN RAYMOND MCGRATH WAS UNABLE TO JOIN US TODAY BUT HAS REQUESTED THAT HE BE PERMITTED TO SUBMIT A STATEMENT FOR INCLUSION IN THE HEARING RECORD. WITHOUT OBJECTION, IT IS SO ORDERED AND THE HEARING RECORD WILL REMAIN OPEN FOR FIVE DAYS FOLLOWING THE HEARING FOR THE INCLUSION OF ADDITIONAL STATEMENTS.

STATEMENT OF THE HONORABLE HAMILTON FISH, JR.
BEFORE THE HOSPITAL AND HEALTH CARE SUBCOMMITTEE OF
THE HOUSE COMMITTEE ON VETERANS' AFFAIR

MAY 18, 1989

I appreciate the opportunity to testify before the House Veterans Affairs Subcommittee on Hospitals and Health Care in conjunction with its May 15, 1989, hearing at Northport, New York.

Mr. Chairman, recently I received hundreds of petitions from concerned citizens in my District. Their petition states: "Please be advised, because of the recent past budget cuts passed by our Congress, Veterans, wounded veterans in our Veterans hospitals are not being given care that they need to survive, to become productive citizens once again. Our need is to persuade our Congress and Representatives to reinstate the funds that are necessary to accomplish this goal of helping veterans, the veterans who cannot help themselves."

The petition continues, "We the undersigned demand that the one billion dollars that was cut from the Veterans Administration fund to support Veterans Hospitals be restored immediately, and without question."

The House of Representatives has added $340 million to this year's spending for veterans health care.

I commend the House Veterans Affairs Committee for recommending that $1.3 billion be added to medical-related funding levels for next year's Fiscal 1990 budget, of which $1.1 billion would be devoted to direct medical care. As you know, the final version of the budget resolution passed by the House of Representatives and the Senate contains a direct medical care account of $821 million. This is a good start, but we all know that more money will be needed next year.

Mr. Chairman, later this month our Nation will celebrate Memorial Day by honoring the servicemen who have given their lives to defend our freedoms. They answered their call to duty, and today we, too, have a duty to honor all our veterans. And we have a special covenant to provide them with quality health care. I am willing and eager to work with my colleagues on the Veterans Committee to ensure that we keep this covenant.

Thank you.

STATEMENT OF THE HONORABLE RAYMOND J. MCGRATH
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER AT NORTHPORT HEARING
MAY 15, 1989

I would first like to thank Representative Bruce Morrison for chairing this field hearing of the Subcommittee on Hospitals and Health Care. I truly believe that veterans have a good friend and viable ally in the House Committee on Veterans Affairs and its chairman, Representative Sonny Montgomery. Congressman Montgomery has consistently fought for and crafted legislation designed to benefit our Nation's veterans. In these times when federal spending is becoming more closely scrutinized, the House Committee on Veterans Affairs has kept its commitment to our veterans and their programs. It is hard to predict the exact outcome of the Fiscal Year 1990 appropriations, however, I can assure you that Chairman Montgomery and his fine Committee will keep a watchful eye on the programs that veterans have earned and depend on.

As everyone here knows, the main thrust of this hearing is to find answers to a most troubling concern, the Department of Veterans Affair's recent decision to close two long-term care wards here at Northport.

To say that I am disturbed at this decision is a gross understatement. I am also distressed at the manner in which this decision was announced. As I recollect, no one in the Long Island Congressional delegation was notified beforehand of the eminent cutbacks. I found out through a much publicized article in NEWSDAY. It was later reported that no patients would be forced to leave until the long-term facility here at Northport is completed, however, these conflicting reports have not added to the already tarnished reputation of Northport or the DVA.

Supplemental DVA appropriations for this Fiscal Year and the recent House approval of a $264 million increase in discretionary spending for veterans programs in the Fiscal Year 1990 budget are steps in the right direction. However, the work does not stop there. Hearings such as this serve as an oversight tool, an instrument to prevent incidents like this from ever happening again and to insure the veteran community that we hear their cry.

I regret that I could not be here today to deliver my statement in person. I again want to thank Congressman Morrison for chairing this hearing and for including my statement in the record.

TESTIMONY

BY

ALBERT B. WASHKO

REGIONAL DIRECTOR, NORTHEASTERN REGION

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

MY TESTIMONY TODAY WILL FOCUS ON THREE MAIN AREAS. FIRST, THE IMPACT OF LIMITED RESOURCES ON THE QUALITY AND QUANTITY OF CARE PROVIDED TO VETERANS IN THE NORTHEASTERN REGION. SECONDLY, PROBLEMS WITH RECRUITMENT AND RETENTION WHICH ADVERSELY EFFECT BOTH QUALITY AND QUANTITY OF SERVICES PROVIDED. THIRD, WHAT THE NORTHEAST REGION IS DOING TO PROMOTE QUALITY CARE TO OUR VETERAN PATIENTS.

IMPACT OF LIMITED RESOURCES ON QUALITY OF CARE

I HAVE BECOME INCREASINGLY CONCERNED WITH HOW LIMITED RESOURCES ARE AFFECTING QUALITY OF CARE PROVIDED TO THE VETERANS IN THE NORTHEASTERN REGION. AT THE ADVICE OF SOME KEY CLINICAL AND ADMINISTRATIVE LEADERS IN THIS REGION, I ASKED ALL OF THE DIRECTORS TO RESPOND TO SOME SPECIFIC QUESTIONS I POSED TO PROVIDE ME WITH A BETTER PERSPECTIVE CONCERNING THIS ISSUE. I WILL SHARE WITH YOU SOME OF THE INFORMATION THAT THE DIRECTORS IN THIS REGION PROVIDED IN NOVEMBER OF 1988 IN ORDER TO GIVE YOU SOME INDICATION OF THE IMPACT OF LIMITED RESOURCES ON THE QUALITY OF CARE PROVIDED TO OUR VETERANS.

WHILE THE INFORMATION WAS OBTAINED LAST NOVEMBER, I BELIEVE THAT IT ACCURATELY REFLECTS THE CURRENT SITUATION THAT MOST FACILITIES ARE EXPERIENCING. NONETHELESS, I AM IN THE PROCESS OF REASSESSING THIS SITUATION IN ORDER TO OBTAIN A MORE CURRENT PERSPECTIVE.

I WILL PROVIDE FOUR CATEGORIES OF INFORMATION WHICH I RAISE CONCERNS REGARDING THE QUALITY OF CARE PROVIDED TO VETERANS IN THE NORTHEASTERN REGION AND REQUIRE CAREFUL MONITORING ON OUR PART:

- INABILITY TO FUND PATIENT CARE EQUIPMENT NEEDS,
- ELIMINATION OR LIMITATION OF KEY SERVICES,
- EXCESSIVE WAITING TIMES FOR CLINIC APPOINTMENTS AND
- EXCESSIVE WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE

I CONSIDER THE INABILITY TO FUND PATIENT CARE EQUIPMENT NEEDS AS A MATTER OF REAL CONCERN FOR THE NORTHEASTERN REGION BECAUSE THIS DIRECTLY AFFECTS THE DIAGNOSIS AND TREATMENT OF VETERANS. IN NOVEMBER OF 1988, DIRECTORS IN THE NORTHEASTERN REGION WERE ASKED TO IDENTIFY PATIENT CARE RELATED REPLACEMENT EQUIPMENT NEEDS WHICH COST GREATER THAN $50,000 FOR INDIVIDUAL OR MULTIPLE ITEMS AND WHICH COULD NOT BE FUNDED IN FY 89.

THE MEDICAL CENTER HERE AT NORTHPORT IDENTIFIED APPROXIMATELY $1,876,000 IN NEEDED REPLACEMENT EQUIPMENT. THE NORTHEASTERN REGION HAD A TOTAL OF APPROXIMATELY $38,000,000 OF REPLACEMENT EQUIPMENT NEEDS COSTING GREATER THAN $50,000 FOR INDIVIDUAL OR MULTIPLE ITEMS.

IN NOVEMBER, THE MAJORITY OF THE NORTHEASTERN REGION'S DIRECTORS ALSO REPORTED INFORMATION WHICH INDICATED THAT KEY SERVICES ARE LIMITED OR NO LONGER AVAILABLE. WHILE THE TYPE OF SERVICES VARIED ACROSS FACILITIES, ALL FACILITIES REPORTED KEY SERVICES WHICH HAVE BEEN AFFECTED.

IN GENERAL, THE LIST OF KEY SERVICES WHICH HAVE BEEN LIMITED OR ARE NO LONGER PROVIDED AFFECTS THE QUALITY OF CARE IN AT LEAST SEVERAL WAYS: BY CAUSING DELAYS IN DIAGNOSIS OR IN TREATMENTS; BY CAUSING A DECREASE IN THE AMOUNT OF TIME THAT CAN BE DEVOTED TO QUALITY ASSURANCE ACTIVITIES.

ANOTHER AREA THAT I ASKED DIRECTORS ABOUT WAS EXCESSIVE WAITING TIMES FOR CLINIC APPOINTMENTS. THESE TIMES VARY ACROSS FACILITIES BY TYPE OF CLINIC BUT THE MAJORITY OF THE NORTHEASTERN REGION FACILITIES REPORT EXCESSIVE WAITING TIMES IN AT LEAST SOME OF THEIR CLINICS. AGAIN, IN GENERAL, THIS AFFECTS QUALITY OF CARE BY CAUSING DELAYS IN DIAGNOSIS OR IN PROVIDING TREATMENTS.

FINALLY, INFORMATION ABOUT WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE INDICATES THE EFFECTS OF LIMITED RESOURCES ON QUALITY. AGAIN THESE TIMES VARY ACROSS THE REGION IN TERMS OF THE NUMBER OF PATIENTS AFFECTED AND THE WAITING TIMES BUT THE MAJORITY OF FACILITIES IN THE NORTHEASTERN REGION REPORT EXCESSIVE TIMES.

IN GENERAL, WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE INDICATES THAT SERVICES, THE MAJORITY BEING ACUTE CARE, ARE BEING INAPPROPRIATELY USED FOR PATIENTS WHO DO NOT HAVE THESE NEEDS. FOR EXAMPLE, USING ACUTE CARE SERVICES FOR PATIENTS WITH LONG TERM CARE (NURSING HOME) NEEDS. MOREOVER, PATIENTS IN AN APPROPRIATE SETTING, SUCH AS LONG TERM CARE PATIENTS IN AN ACUTE CARE WARD, WILL NOT HAVE THEIR LONG TERM CARE NEEDS ADEQUATELY ADDRESSED.

IN NOVEMBER OF 1988, THE MAJORITY OF THIS REGION'S FACILITIES REPORTED WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE. AT THE MEDICAL CENTER HERE AT NORTHPORT, 43 PATIENTS WERE WAITING AN AVERAGE OF 56 DAYS.

RECRUITMENT AND RETENTION ISSUES

IN 1988 AND 1989, THE FEDERAL EXECUTIVE BOARD IN NEW YORK CITY AND BOSTON PUBLISHED STUDIES ON THE EFFECTS OF PAY POLICY ON PUBLIC SERVICE. THESE STUDIES HIGHLIGHT AN EMPLOYMENT CRISIS. THE FEDERAL GOVERNMENT CAN NO LONGER COMPETE WITH PRIVATE INDUSTRY FOR QUALITY EMPLOYEES AND FEDERAL EMPLOYERS ARE FINDING IT INCREASINGLY DIFFICULT TO HIRE AND RETAIN GOOD AND BRIGHT EMPLOYEES WHO CAN PROVIDE QUALITY, TIMELY, AND RELIABLE PUBLIC SERVICES.

THE SALARY GAP BETWEEN THE PUBLIC AND PRIVATE SECTORS IS IN EXCESS OF 25 PERCENT AND THE GAP IS INCREASING. OVER TIME, THIS TREND WILL FURTHER ERODE THE FEDERAL GOVERNMENT'S ABILITY TO COMPETE IN THE LOCAL LABOR MARKET.

THE HEALTH AND WELL BEING OF HUNDREDS OF THOUSANDS OF AMERICAN VETERANS IS THE RESPONSIBILITY OF THE VARIETY OF TECHNICAL AND PROFESSIONAL EMPLOYEES OF 172 VA MEDICAL CENTERS. THE INABILITY TO PROPERLY STAFF THE MEDICAL CENTERS IS NOT ONLY A BUDGET ISSUE BUT A PAY ISSUE. THE FOLLOWING IS A BRIEF SYNOPSIS OF SOME OF THE CRITICAL STAFFING PROBLEMS AT THREE VA MEDICAL CENTERS IN THE NORTHEAST.

VAMC BOSTON

REGISTERED NURSES (RN'S)

AT THE PRESENT TIME, BOSTON HAS VACANT RN POSITIONS WHICH EQUATE TO 47.1 FTEE. THEY ARE UTILISING FEE BASIS RN'S WHO RECEIVE: $23/HR FOR WEEKDAYS; $24/HR EVEN/NIGHTS; AND $24/HR WEEKEND DAYS; AND $25/HR WEEKEND EVEN/NIGHTS. AGENCY RN COSTS AVERAGE ABOUT $1,200/DAY. ACCORDINGLY, THE ESTIMATED COST OF A FEE BASIS NURSE IS $52,000 AND FOR A CONTRACT NURSE $65 TO $75,000 ANNUALLY.

WITH THE COST OF LIVING INCREASE IN JANUARY 1989, AND THE CURRENT SPECIAL RATES FOR RN'S, WE ARE PAYING OUR JUNIOR GRADE NURSES $28,072 (EQUIVALENT TO JUNIOR/19), AND ASSOCIATE GRADE NURSES $32,833 (EQUIVALENT TO ASSOCIATE/19). HOWEVER, THEY ARE STILL NOT COMPETITIVE SINCE THE COMMUNITY OFFERS ON AN AVERAGE $3,300 MORE IN SALARY FOR JUNIOR GRADE RN'S THAN WE DO AND $3,677/YR MORE TO ASSOCIATE GRADE NURSES. THIS DOES NOT TAKE INTO CONSIDERATION THE BONUS MONEY PAID BY LOCAL HOSPITALS ($2,000) IF THE NURSE WILL REMAIN WITH THE HOSPITAL FOR A YEAR.

THE CURRENT SPECIAL RATES FOR NURSES AT THE JUNIOR AND ASSOCIATE GRADE LEVELS ARE THE HIGHEST LEGAL LEVEL VACO CAN GO AND IT WILL TAKE LEGISLATION TO RAISE THIS CAP IF WE ARE TO BE ABLE TO MEET THE COMMUNITY RATES IN THE FUTURE.

LICENSED PRACTICAL NURSES (LPN'S)

AT THE PRESENT TIME BOSTON HAS 54.2 FTEE IN VACANT LPN POSITIONS. THE LATEST SURVEY TO SUPPORT A NEW SPECIAL RATE FOR LPN'S REFLECTS THAT THE MINIMUM RATE OFFERED IN THE COMMUNITY FOR NEW GRADUATES IS $23,676/YR VERSUS OUR MAXIMUM SALARY OF $19,649/YR GS-3 LPN'S. THE AVERAGE RATE FOR LPN'S IN THE COMMUNITY EQUAL TO OUR GS-6 LEVEL RECEIVE $30,927/YR VERSUS OUR MAXIMUM RATE OF $2[illegible],379/YR. ACCORDINGLY, THEY ARE BEHIND AN AVERAGE OF $4,027/YR AT THE GS-3 LEVEL AND $4,548/YR AT THE GS-6 LEVEL. ANY NEW SPECIAL RATE WILL BE LIMITED BY LEGISLATED MAXIMUM ENTRY LEVELS.

RADIOLOGY TECHS

AT THE PRESENT TIME, BOSTON VAMC HAS 19.7 FTEE IN VACANT RADIOLOGY TECH POSITIONS (OUT OF 36 FTEE AUTHORISED). A NEW SPECIAL RATE PACKAGE HAS BEEN SUBMITTED TO OPM WHICH WILL COVER GS-4 TO GS-11 WITH MINIMUM A RATE OF $22,509 (GS-4) TO $36,548 (GS-11). INFORMATION PROVIDED FROM THE SERVICE AND APPLICANTS HAS INDICATED THAT THESE MAY BE CONSERVATIVE AND NOT AS ATTRACTIVE AS LOCAL HOSPITAL RATES. A SHORTAGE OF QUALIFIED APPLICANTS HAS EXISTED IN THIS CITY FOR ABOUT THREE YEARS; AND AS THE TECHNOLOGY EXPANDS, MORE STAFF TECHS ARE SELECTING SPECIALISED FIELDS WITHIN RADIOLOGY. OUR ANNUAL COST OF A CONTRACT RADIOLOGY TECH IS APPROXIMATELY $50,000.

VAMC BROOKLYN

DURING THE LAST FEW YEARS, THE PAY DISPARITY BETWEEN FEDERAL EMPLOYEES AND THE PRIVATE SECTOR HAS INCREASED TO THE POINT THAT RECRUITMENT IN SOME AREAS IS VIRTUALLY IMPOSSIBLE. THIS PROBLEM IS PARTICULARLY CRITICAL WITH THOSE POSITIONS THAT PROVIDE DIRECT AND INDIRECT PATIENT CARE. THERE ARE MANY EXAMPLES WHICH COULD BE CITED.

BROOKLYN VAMC HAS TRIED TO ALLEVIATE THE PROBLEM OF PAY DISPARITY THROUGH THE USE OF SPECIAL RATES. HOWEVER, DUE TO THE WIDENING GAP, EVEN THE INSTITUTION OF SPECIAL RATES HAS MANY TIMES NOT IMPROVED RECRUITMENT. THE MOST GLARING EXAMPLE OF THIS IS THE TROUBLE BROOKLYN HAS EXPERIENCED IN RECRUITING PHYSICAL AND OCCUPATIONAL THERAPISTS. IN 1987, THEY INCREASED THE SPECIAL RATES FOR THESE POSITIONS TO THE MAXIMUM EXTENT POSSIBLE. HOWEVER, THEY STILL WERE NOT ABLE TO ATTRACT APPLICANTS. THEY SIMPLY COULD NOT COMPETE WITH THE PRIVATE SECTOR IN TERMS OF SALARIES AND BENEFITS. IN VIEW OF THIS, THEY WERE FORCED TO CONTRACT FOR PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS WHICH LAST YEAR COST THEM $42.00 PER HOUR. THIS EQUATES TO $88,000 PER PERSON, PER YEAR, ON CONTRACT. CURRENTLY, THE MOST THEY COULD OFFER A GS-9 STEP 10 ON THEIR SPECIAL RATES WOULD BE $36,636. THEIR TOTAL CONTRACT WAS APPROXIMATELY $300,000 FOR THE YEAR. THEY HAVE BEEN INFORMED THAT THE HOURLY RATE HAS INCREASED TO $47.00 PER HOUR.

BROOKLYN NOW FACES A SIMILAR PROBLEM WITH DIAGNOSTIC RADIOLOGIC TECHNOLOGISTS. THEY RECEIVED SPECIAL RATES IN JANUARY, 1988. THEY CURRENTLY HAVE A REQUEST PENDING WITH OPM FOR AN INCREASE IN RATES. DESPITE ACTIVE RECRUITMENT EFFORTS, THEY HAVE BEEN UNABLE TO RECRUIT ANY DIAGNOSTIC RADIOLOGIC TECHNOLOGISTS. SEVERAL ADS HAVE BEEN RUN IN THE NEW YORK TIMES OVER THE LAST FEW WEEKS. TO DATE, THEY HAVE NOT RECEIVED EVEN ONE RESPONSE TO AN AD.

WITH THE SUMMER MONTHS COMING, THEY ARE EXTREMELY CONCERNED ABOUT VACATION COVERAGE. THEIR ONLY ALTERNATIVE MAY BE TO CONTRACT OUT. THE APPROXIMATE COST OF CONTRACTING OUT WOULD BE $40.00 PER HOUR. THIS WOULD EQUATE TO APPROXIMATELY $83,000 PER YEAR. A GS-7 STEP 10 ON SPECIAL RATES CURRENTLY MAKES $29,940 PER YEAR.

BROOKLYN VAMC HAS BEEN RECRUITING FOR SOME DIETITIAN AND POLICE OFFICER VACANCIES FOR MORE THAN A YEAR IN SPITE OF THE EXISTENCE OF SPECIAL RATES AND ACTIVE RECRUITMENT EFFORTS. NEEDLESS TO SAY, THE PAY DISPARITY IS HAVING AN ADVERSE EFFECT ON QUALITY PATIENT CARE. RECENTLY A "HEAD-HUNTING' FIRM OFFERED THEIR CHIEF, DIETETIC SERVICE $70,000 AS AN ADMINISTRATIVE DIETITIAN. A GS-11 STEP 10 ADMINISTRATIVE DIETITIAN MAKES $38,659 ON OUR SPECIAL RATE SCALE.

THE FEDERAL PAY DISPARITY HAS ALSO HINDERED THEIR ABILITY TO RECRUIT TITLE 38 SERVICE CHIEFS. BROOKLYN HAS BEEN RECRUITING FOR A CHIEF, SURGICAL SERVICE FOR NEARLY TWO YEARS; THE CHIEF, RADIOLOGY SERVICE LEFT IN DECEMBER, 1988; AND THEY ARE NOT OPTIMISTIC IN FILLING THIS POSITION ANYTIME IN THE NEAR FUTURE DESPITE ACTIVE RECRUITMENT EFFORTS AND ENHANCEMENTS MADE BY THEM AND DOWNSTATE MEDICAL CENTER. TO COMPOUND THIS PROBLEM, THEY ANTICIPATE THAT THE CHIEF, ANESTHESIOLOGY SERVICE WILL BE RETIRING THIS FALL. RECRUITING A REPLACEMENT QUICKLY IS DOUBTFUL. CONTRACTING OF THESE POSITIONS WOULD BE WELL OVER $200,000.

THE ABOVE PAY DISPARITY IS NOT UNIQUE TO THE VA. IT IS A SEVERE PROBLEM WHICH EXISTS IN ALL FEDERAL AGENCIES IN THE NEW YORK CITY AREA.

IN AUGUST 1988, THE NEW YORK FEDERAL EXECUTIVE BOARD BEGAN WORKING WITH THE FBI ON A SPECIAL PAY PROJECT FOR THE ENTIRE NYC AREA. THIS PROJECT WAS AN EFFORT TO ADDRESS THE GROWING CRISIS FACING THE FEDERAL GOVERNMENT IN NEW YORK IN TERMS OF RECRUITING AND RETAINING A QUALIFIED WORK FORCE. SINCE AUGUST, THE FEB HAS BEEN GATHERING AND PRESENTING DATA IN ACCORDANCE WITH THE SPECIAL SALARY RATES PROCESS. BASED ON THESE STUDIES, CRITICAL STAFFING SHORTAGES HAVE BEEN REPORTED AMONG PROFESSIONAL, ADMINISTRATIVE, TECHNICAL AND CLERICAL EMPLOYEES. THERE IS ALSO A GROWING CONCERN ABOUT THE POTENTIAL IMPACT THIS LOWER QUALITY WORK FORCE WILL HAVE ON AGENCY AND DEPARTMENT OPERATIONS.

THE FEB HAS FOUND THAT THERE IS A GAP OF MORE THAN 25 PERCENT BETWEEN GOVERNMENT SALARIES AND WAGES IN THE PRIVATE SECTOR. THERE IS A TREMENDOUS PRIVATE SECTOR JOB GROWTH, COMBINED WITH A TIGHT LABOR MARKET, AND THE RESULT IS SEVERE RECRUITMENT AND RETENTION PROBLEMS FOR FEDERAL AGENCIES IN THE AREA. THE NEW YORK AREA HAS THE HIGHEST COST OF LIVING IN THE NATION WITH THE POSSIBLE EXCEPTION OF ANCHORAGE, ALASKA; A CITY THAT IS SUPPLEMENTED BY A 25 PERCENT COLA.

IN OCTOBER 1988, THE FEB SUBMITTED A GROUP OF 81 OCCUPATIONAL SERIES TO THE OFFICE OF PERSONNEL MANAGEMENT FOR CONSIDERATION UNDER THE SPECIAL SALARY RATE REGULATION. OPM ADVISED THE FEB, IN ITS ROLE AS LEAD AGENCY, TO SELECT THE MOST SEVERE PROBLEMS AMONG THE MULTI-AGENCY SERIES FOR CONSIDERATION UNDER THE SPECIAL SALARY RATE PROCESS, AS CITED IN 5 USC §303. THE FEB HAS REVIEWED THE DATA FOR ALL SERIES AND HAS SELECTED 28 MULTI-AGENCY SERIES WHICH REPRESENT THE MOST SEVERE PROBLEMS IN TERMS OF RECRUITMENT AND RETENTION. A PACKAGE REQUESTING SPECIAL RATES FOR THESE 28 OCCUPATIONS HAS BEEN SUBMITTED TO OPM FOR APPROVAL.

FEB HAS ASKED BROOKLYN TO SUBMIT THE APPROPRIATE SPREAD-SHEETS AND NARRATIVES WHICH THEY HAVE COMPLETED TO VA CENTRAL OFFICE AS SOON AS POSSIBLE, REQUESTING APPROVAL AND CERTIFICATION OF FUNDS TO SUPPORT SPECIAL SALARY RATES FOR THOSE SERIES THAT ARE APPLICABLE TO THE BRONX, MANHATTAN AND BROOKLYN VA'S.

V.A. MEDICAL CENTER NEW YORK

COST COMPARISON

EMPLOYMENT VS CONTRACT

CURRENT CONTRACT COSTS

SERVICE	POSITION	# STAFF	VA SALARY	CONTRACT COST
MAS	TELEPHONE OPERATORS	6	$6.74PH	$12.00PH
RADIOLOGY	DRT	6	$10.71PH*	$32.50PH
ANESTHESIOLOGY	PHYSICIAN (CHIEF)	1	$94,121**	$255,920**

* SALARY BASED ON GS-6 STEP 1 (SPECIAL RATE)

** VA SALARY FOR CHIEF ANESTHESIOLOGY INCLUDES 19,181 BONUS

CONTRACT COST INCLUDES $26,000 FOR MALPRACTICE INSURANCE,

WHICH EMPLOYEE'S WOULD NOT CARRY IF EMPLOYED BY VA.

POTENTIAL AREAS WHICH MAY BE CONTRACTED OUT

SERVICE	POSITION	# STAFF	VA SALARY	CONTRACT COST
SECURITY	POLICE OFFICER	4	$ 8.37PH*	$12.00PH
MEDICAL	ECHO TECH	1	$14.85PH**	$20.00PH
RMS	PHYSICAL	3	$15.68PH***	$21.00PH

* BASED ON A GS-5 STEP 1 (SPECIAL RATE)

** BASED ON A GS-9 STEP 9 (GENERAL SCHEDULE)

*** BASED ON A GS-9 STEP 5 (SPECIAL RATE) .

PHYSICIAN RECRUITMENT/RETENTION

PHYSICIAN RECRUITMENT AND RETENTION HAS ALSO DETERIORATED. I AM BECOMING INCREASINGLY CONCERNED WITH THE INABILITY OF MANY OF OUR VA MEDICAL CENTERS TO RECRUIT AND RETAIN WELL QUALIFIED PHYSICIANS. WE RECENTLY SURVEYED THE 33 VAMC'S IN THE NORTHEASTERN REGION TO ASSESS THE MAGNITUDE OF THE PROBLEM AND TO DETERMINE IF PHYSICIAN RECRUITMENT AND RETENTION WAS ADVERSELY AFFECTING THE QUALITY PATIENT CARE.

WE FOUND THAT 21 OF 23 VAMC'S ARE EXPERIENCING RECRUITING DIFFICULTIES IN ONE OR MORE PHYSICIAN CATEGORIES. THREE MEDICAL CENTERS HAVE VACANCIES FOR RADIOLOGISTS, PSYCHIATRISTS, ORTHOPEDISTS, AND CARDIO-VASCULAR SURGEONS IN EXCESS OF ONE YEAR. MOST MEDICAL CENTERS ARE ABLE TO RECRUIT JUNIOR, ENTRY LEVEL, PHYSICIANS IN INTERNAL MEDICINE AND AMBULATORY CARE BUT EXPERIENCE GREAT DIFFICULTY IN RECRUITING ENTRY LEVEL PSYCHIATRISTS, RADIOLOGISTS, ANESTHESIOLOGISTS, AND SUB-SPECIALTY SURGEONS. RECRUITMENT OF MORE SENIOR PHYSICIANS WITH MORE ADVANCED EXPERIENCE AND SKILLS IS EXTREMELY DIFFICULT AND LEAVES CLINICAL SERVICES WITHOUT ADEQUATE SUPERVISION, LEADERSHIP AND EXPERTISE.

SALARIES AND FRINGE BENEFITS WHICH ARE NOT COMPETITIVE WITH THE ACADEMIC AND PRIVATE SECTOR ARE THE MAJOR NEGATIVE FACTORS IN RECRUITMENT AND RETENTION. THE SALARY GAP WIDENS IN THE MORE SENIOR LEVEL POSITIONS. THE RESULTING "COMPRESSION" OF PAY LEVELS CAUSES A MAJOR RETENTION PROBLEM WITH VA STAFF WHO HAVE FACULTY APPOINTMENTS AT ASSOCIATE AND FULL PROFESSOR LEVELS BUT WHOSE SALARY IS COMMENSURATE WITH INSTRUCTOR AND ASSISTANT PROFESSOR FACULTY AT OTHER AFFILIATED HOSPITALS.

WHAT THE NORTHEAST REGION IS DOING TO PROMOTE QUALITY

I AM DEEPLY CONCERNED AND COMMITTED TO PROVIDING HIGH QUALITY OF CARE TO OUR VETERANS. FROM THE TIME I BECAME THE DIRECTOR OF THE NORTHEASTERN REGION, I HAVE AGGRESSIVELY PROMOTED AND SUPPORTED THE MANAGEMENT OF QUALITY. IN ADDITION TO ADEQUATE RESOURCES, INCLUDING BOTH PERSONNEL AND EQUIPMENT, I HAVE IDENTIFIED TWO ESSENTIAL ELEMENTS FOR ACHIEVING HIGH QUALITY OF CARE. THEIR IMPLEMENTATION WILL RESULT IN ESTABLISHING A CYCLE OF CONTINUOUS IMPROVEMENT. TO ACHIEVE HIGH QUALITY CARE, TWO PROCESSES ARE REQUIRED: 1) SERVICE MANAGEMENT AND 2) QUALITY MANAGEMENT.

SERVICE MANAGEMENT IS A MANAGEMENT PHILOSOPHY WHICH IS BEING COMMUNICATED TO ALL MANAGERS AND EMPLOYEES IN THE NORTHEAST REGION. THE KEY CONCEPT IN THIS MANAGEMENT PHILOSOPHY IS EXCELLENCE IN THE PROVISION OF SERVICE; SERVICE TO OUR VETERAN PATIENTS AND THEIR FAMILIES AND SERVICE TO EACH OTHER AS FELLOW EMPLOYEES AND COLLEAGUES. OUR OUTCOME VISION FOR SERVICE EXCELLENCE MANAGEMENT IS TO HAVE THE BEST MANAGED MEDICAL CENTERS IN THE COUNTRY; TO PROVIDE A HIGH CONSISTENT LEVEL OF SERVICE AND PERCEIVED QUALITY OF SERVICE TO PATIENTS, EMPLOYEES AND PHYSICIANS; AND TO PROVIDE AN ENHANCED EMPLOYEE AND MANAGEMENT CLIMATE FOR OUR PEOPLE TO WORK IN.

THERE ARE A NUMBER OF STRUCTURES IN PLACE TO SUPPORT THIS VISION, INCLUDING FIVE SEMINARS/WORKSHOPS FOR EVERY MANAGER IN THE NORTHEAST REGION AND TWO SEMINARS/WORKSHOPS FOR ALL EMPLOYEES. THIS TRAINING IS BEING PROVIDED BY MANAGEMENT COLLEGE FACULTY FROM WITHIN THE NORTHEAST REGION AND MYSELF. IN ADDITION, THERE ARE FIVE DATA SYSTEMS WHICH WILL SUPPORT THE ACCOMPLISHMENT OF OUR VISION. THESE ARE INSTRUMENTS WHICH MEASURE THE MANAGEMENT CLIMATE, EMPLOYEE CLIMATE, SERVICES PROVIDED TO EACH OTHER, SERVICES PROVIDED TO PHYSICIANS AND SERVICE PROVIDED TO PATIENTS.

SOME SPECIFIC OUTCOMES WHICH I HOPE TO ACCOMPLISH THROUGH THE SERVICE EXCELLENCE MANAGEMENT PROCESS IN THE NORTHEASTERN REGION ARE: 1) SETTING JOB STANDARDS WITHIN EACH SERVICE OR SECTION FOR ENCOUNTERS WITH VETERANS; THROUGH THE ACHIEVEMENT OF THESE STANDARDS, MAXIMIZE THE VETERAN'S, HIS OR HER FAMILY'S AND THE COMMUNITY'S PERCEPTION OF QUALITY SERVICE WITHIN EACH MEDICAL CENTER; 2) RECOGNIZE THE 'INTERNAL CUSTOMER' AND CREATE A HIGH LEVEL OF CONSISTENCY OF SERVICE THAT ONE EMPLOYEE RECEIVES FROM OTHER EMPLOYEES, SECTIONS AND SERVICES; 3) CONTINUE TO BUILD MORE POSITIVE EMPLOYEE MORALE AND MANAGEMENT CLIMATE; 4) PROVIDE THE TOP MANAGEMENT TEAM IN EACH FACILITY WITH CONCISE EASY-TO-USE DATA TO KNOW HOW WELL THEIR HOSPITAL IS WORKING FROM A SERVICE DELIVERY AND AN EMPLOYEE AND MANAGEMENT CLIMATE STANDPOINT.

THE ESTABLISHMENT OF A QUALITY MANAGEMENT PHILOSOPHY AND INFORMATION SYSTEM IS THE SECOND PHASE IN MY STRATEGY, WHICH INVOLVES THE IMPLEMENTATION OF A MANAGEMENT COLLEGE TO TEACH STATISTICAL QUALITY CONTROL METHODS TO ALL STAFF. THROUGH A SYSTEM OF SEMINARS BEING PLANNED FOR NEXT YEAR, EVERY EMPLOYEE WILL LEARN THAT THEY HAVE A RESPONSIBILITY IN THE MANAGEMENT OF PATIENT CARE AND THAT THEIR ACTIONS CONTRIBUTE TOWARD THE ACHIEVEMENT OF HIGH QUALITY OF CARE IN THEIR HOSPITALS.

AGAIN, EVERY DIRECTOR AND HIS OR HER STAFF IN THE NORTHEASTERN REGION WILL BE INVOLVED. THE MEASUREMENT OF QUALITY OF CARE IS CURRENTLY ABSORBING NATIONAL RESOURCES, INCLUDING LEADING MEDICAL AND CLINICAL SOCIETIES, RESEARCH TEAMS AND BOTH GOVERNMENT AND PRIVATE SECTOR AGENCIES. IN SPITE OF THE COMPLEXITY OF THIS TASK, THIS REGION HAS MADE A MAJOR COMMITMENT TO IMPLEMENTING A QUALITY MANAGEMENT PHILOSOPHY AND INFORMATION SYSTEM WHICH APPLIES STATISTICAL QUALITY CONTROL METHODS TO MEASURE THE TECHNICAL ASPECTS OF CARE, (FOR EXAMPLE THE APPROPRIATENESS OF THE TREATMENT REGIMEN), AND OF THE HEALTH CARE DELIVERY SYSTEM IN EACH HOSPITAL (FOR EXAMPLE, THE ADEQUACY OF COMMUNICATING ABNORMAL TEST RESULTS, OR THE TIMELINESS OF SURGERY). FEW HEALTH CARE INSTITUTIONS HAVE MADE A COMMITMENT TO SUCH AN AMBITIOUS UNDERTAKING.

SPECIFICALLY, THE ESTABLISHMENT AND USE OF A COMPREHENSIVE QUALITY MANAGEMENT INFORMATION SYSTEM WILL PROVIDE THE CLINICIAN AT THE BEDSIDE, (A PHYSICIAN, NURSE OR SOCIAL WORKER), WITH TECHNICAL INFORMATION ABOUT THE QUALITY OF CARE FOR THE PURPOSE OF ACHIEVING THE BEST CLINICAL MANAGEMENT; FOR EXAMPLE, THE EARLY IDENTIFICATION OF UNEXPECTED COMPLICATIONS IN SURGICAL PATIENTS, THE EARLY DETECTION OF AN INAPPROPRIATELY PRESCRIBED TREATMENT FOR A PATIENT WITH CHRONIC LUNG PROBLEMS AND THE EVALUATION OF THE ADEQUACY OF DISCHARGE PLANS FOR DIABETIC PATIENTS LIVING ALONE.

THIS INFORMATION SYSTEM WILL ALSO CONTAIN DATA FOR MANAGERS AND WORKERS IN EACH HOSPITAL ABOUT THE EFFECTIVENESS OF THE HEALTH CARE DELIVERY SYSTEM IN THAT HOSPITAL SUCH AS THE TIMELINESS OF TESTS OR OTHER TYPES OF INFORMATION AND THE ADEQUACY OF ADMINISTRATIVE PROCEDURES. CONSEQUENTLY, EACH EMPLOYEE WILL BE ABLE TO SEE HOW HE OR SHE CONTRIBUTES TOWARD THE QUALITY OF CARE IN THEIR OWN INSTITUTION.

FINALLY, THE USE OF LONGITUDINAL PATIENT CARE AND DELIVERY SYSTEM INFORMATION WILL PROMOTE A PROCESS OF CONTINUOUS IMPROVEMENT BY BOTH CLINICIANS AND KEY HOSPITAL MANAGERS BECAUSE WE WILL BE ABLE TO MORE QUICKLY IDENTIFY THE BEST WAYS OF MANAGING THE VARIOUS TYPES OF CARE AND DELIVERY SYSTEM FUNCTIONS. MEDICAL CARE CAN ALWAYS FIND BETTER METHODS TO DIAGNOSE AND TREAT PATIENTS AND MANAGERS CAN ALWAYS FIND BETTER WAYS OF OPERATING. WE NEED HOWEVER TO COMMIT TO A PHILOSOPHY OF QUALITY MANAGEMENT AND CONTINUOUS IMPROVEMENT TO FIND THESE BETTER WAYS AND WE NEED TO IMPLEMENT AN OBJECTIVE QUALITY MANAGEMENT SYSTEM TO ACHIEVE THIS CONTINUOUS IMPROVEMENT PROCESS.

IN SPITE OF THE ACTIONS OF THIS REGION WHICH DEMONSTRATE OUR COMMITMENT TO QUALITY MANAGEMENT, I BELIEVE THAT OUR DIMINISHING RESOURCES MAY PROVIDE AN INSURMOUNTABLE OBSTACLE IN THE NEAR FUTURE. IN SHORT, QUALITY MANAGEMENT ACTIVITIES WILL ONLY RESULT IN THE DELIVERY OF HIGH QUALITY OF CARE WHEN THERE ARE ADEQUATE RESOURCES.

Department of Veterans Affairs

Regional Director
Northeastern Region
P. O. Box 8500
Albany, N. Y. 12208

In Reply Refer To : (10BA1)

August 29, 1989

Mr. Victor Raymond
House Veterans Affairs Committee
335 Common House Building
Washington, DC 20515

Dear Mr. Raymond,

This is a response to the House Veterans Affairs Committee's request for information concerning the supplemental appropriation for FY 89. Northport, New York Veterans Administration Medical Center received $1,099,787 in regular operating funds.

Sincerely,

AL WASHKO
Regional Director
Northeast Region

PREPARED STATEMENT OF BILL MANLY, DIRECTOR NORTHPORT, CT, VA MEDICAL CENTER

My name is Bill Manley. I am the Director of Northort VA Medical Center. I have been at Northort since October, 1985 and with the Department of Veterans Affairs for approximately 25 years.

BUDGET

The Fiscal Year 1986 (FY'86) Target Allowance for Northport VAMC had a Medical Care recurring base of $69,746,488 that would support 1850.2 FTEE. As of March 31, 1989 this recurring base is estimated at $85,510,687; that will support only 1826.3 FTEE. This is a $15,764,199 increase (22.6%) over a four year period or slightly better than 5% compounded annually. With this minimal growth, our employment base has deteriorated by 23.9 FTEE.

The increase in recurring dollars has been used to offset increases in the following recurring earmarked accounts:

Medicare	$ 131,088
Pay Raises (GS, WG, FEHB)	4,982,851
Within Grade Increases	809,966
Thrift Savings Plan	154,504
FERS	1,161,125
FICA	1,049,227
Additional Holiday	45,541
MD and Dentist Bonus (moved from non-rec. to rec.)	1,376,480
Special Salary Rates	4,641,963
TOTAL	$14,352,745

The remaining increase has been used to open an additional 40 bed long-term care ward (in anticipation of opening our new Nursing Home) and minor expansion to the Satellite MHC Program, Alcohol OP Program and the VICTORS Program.

Over this four year period our recurring base has absorbed the following losses:

1% Productivity Costs	$2,667,771	93.0 FTEE
RAM Reductions	3,916,353	96.5 FTEE
Graham-Rudman	250,000	8.0 FTEE
DHCP & Standarized CALM Savings	155,283	2.8 FTEE
TOTAL	$6,989,407	200.3 FTEE

In addition during FY'87 our all other (Non-Personnel) recurring base for supplies and services was $21,047,739 or 27% of the budget. After the expected $1,200,000 withdrawal by VACO, our all other funds this FY'89 will be reduced by $19,958,397; 5% less than two years ago and now represents 24% of the base.

Selected Non-Recurring Funding - Target Allowance

	FY'86	FY'87	FY'88	FY'89
Replacement	$309,441	430,294	327,384	333,404
Additional	284,662	233,156	214,894	--
TOTAL	$594,103	663,450	542,278	333,404

Total dollar value of our CMR Equipment List - $22,354,135.16
(From Total Control Register - March 31, 1989)

N-R Maint.	$842,060	1,491,000	310,000	--

Community Nursing Home Program

FY	Funded Census	Actual Census	$ Funded	$ Spent	Per Diem
86	92	95	$4,082,085	$4,082,083.06	$118
87	95	99	4,566,000	4,565,999.70	126
88	88	100	5,031,742	5,042,197.24	138
89	80	83*	4,344,230	2,122,174.36*	143

* Thru 3/31/89

RCS 10-167, Community Nursing Home (AMIS Segment 349)

WORKLOAD

In the summer of 1986, we had a less than successful recruitment season for Registered Nurses. As the fall approached, our inability to hire RN's impacted on our operation and we were forced to close beds and eventually closed 11A discharging some patients to the CNHC Program and bringing others into the acute care wards. This did result in delaying some elective admissions and created some revenue losses under the RAM system which we are seeing the results of today (this FY). In February, 1987, RN special salary rates were approved and the recruitment of nurses started to meet with some success. By April, 1987, we had reopened about half of the beds on 11A and by June had 11A fully operational.

Also in the summer of 1986, the Chief of Surgery was asked to leave and our Surgical program started to lose work load. By the beginning of FY'87, there was a noticeable decrease in patients treated. This problem continued as we were unable to recruit a Chief for the remainder of FY'87 and into early FY'88. In the winter of 1988, with the financial support of Stony Brook, a local surgeon within the School of Medicine, was located and nominated to VACO. His approval as Chief of Surgery was made in March 1988. After being without strong leadership, the surgical program had lost a significant amount of workload. This is also being felt in this year's target allowance. Since the new Chief has been on board, the surgical program is again on a growth curve.

Of course with the losses in Acute Medicine and Surgery during FY'87, our outpatient workload was also affected. This year (FY'89) a recovery in the outpatient area is also being realized.

RECRUITMENT AND RETENTION

Recruitment has become more difficult over the past few years as the unemployment rate in Nassau/Suffolk has leveled off at a low rate. The rate in January, 1989 was 4.2, up from 3.5 in January, 1988. The quality of candidates, especially in clerical areas, has gradually declined. One of our best sources of employees in past years was the Vietnam Era veteran; we now receive few applicants we can appoint under the Vietnam Readjustment Act.

We are not competitive in our clerical salary rates, at least not sufficiently as to attract those already employed in the private sector, and we continue to lose good employees with experience to the private sector. This is a continuing problem even though we have direct appointing authority thru the GS-4 level and can hire directly "off-the-street".

This has been the basis for dissatisfaction among our currently employed clerical employees. We have been attempting since June, 1987 to obtain special salary rates for our clerical employees. Attachment A is a narrative summary of our efforts to obtain special clerical rates, a chronology, and a list of positions covered.

The fringe benefits that we are now able to offer employees are not always comparable with the private sector, especially with the other health facilities on Long Island who in some instances offer paid health insurance. The retirement package is not as attractive under the Federal Employees Retirement System (FERS) as it was under the old Civil Service Retirement System. There are now rumors that the employee matching fund feature of the FERS may be reduced.

It has become virtually impossible to attract employees from outside the Long Island area to come to Northport because of the high cost of living, especially real estate and real estate taxes. The VA system relies heavily on the upward mobility of people through the system, with people relocating as they move up the career ladder, especially mid and upper management. If we can attract a suitable candidate, we often do not have sufficient travel funds to pay for the relocation, especially when the sale and purchase of a house is involved. This has put a serious limitation on recruitment below top management positions for whom on-station housing is unavailable. It is virtually impossible to locate suitable and affordable housing on current GS/GM salaries. Attachment B is a comparison of salaries in selected administrative and clinical positions between VAMC Northport and other local non-profit healthcare facilities and a comparison with University Hospital, SUNY Stonybrook, a comparable government institution. This survey was conducted by the Nassau/Suffolk Hospital Council.

As of April 8, 1989, we had 139 permanent positions vacant, which is typical. This would not equate to actual vacancies since there are a large number of temporary employees on the rolls. However, the ideal would be to have the positions being utilized fully by having the position filled with the proper permanent employee.

Of the vacancies on April 8, the followinjg hard-to-fill categuries were noted:

Positions	Date Recruitment Began	No. of Vacancies
Industrial Hygienist	5/88	1
Medical Technologist - Microbiology	9/88	2
Respiratory Therapists	9/88	3
Medical Technologist - Hematology	6/88	1
Cardiac Catheter Technician	8/88	1
Nuclear Medicine Technologist	7/87	3
Supervisory Hemodialysis Technologist	1/89	1
Licensed Practical Nurse	12/86	54
Rehabilitation Tech (Alcohol)	12/88	1
Radiology Technologists	5/88	1
Physical Therapist	5/86	3
Occupational Therapist	6/87	6

These positions remain vacant for long periods of time despite special efforts, including extensive advertising, to fill them. Part of the problem is salary and benefits; however, availability is the principal reason these positions are difficult to fill - people with these specialties are not generally available in the Long Island labor market. Private health care facilities often "contract-out" a number of these hard-to-fill categories.

For scarce clinical positions we get some relief using a "Section F" appointing authority which allows us to offer salaries 6% higher than the applicant is currently receiving. This works well for a one of a kind position. The problem with this is we usually do not exceed the salaries of those already employed for fear of losing the employees already in these hard-to-fill positions.

The use of special rates is a method used to recruit and retain employees in some difficult-to-~~recruit~~ positions. The experience cited earlier regarding special rates for clerical positions is unique. While the process is time-consuming we are successful in dealing with VA Central Office in obtaining special rates. The process moves as quickly as the volume of requests received by VACO allows.

We currently have special rates for the following twenty positions:

- Accountant
- EEG Technician
- LPN
- Nursing Assist.
- Pharmacist
- Physical Ther.
- Police Officer
- Registered Nurse
- Respiratory Therapist
- Resp. Ther. (Certified)
- Dietetic Technician
- Engineering
- Nuclear Med. Technician
- Occupational Therapist
- Pharmacy Technician
- Physician Assistant
- Radio Tech (Diag.)
- Radio Tech (Ther.)
- Ultra Sound Tech.
- Respiratory Ther. (Registered)

The present 20 approved special rates cover 36% of the workforce. There are now requests in VACO for 11 new special rates (see Attachment C, p.C-5) which, if approved, will bring the coverage to 56% of the workforce (this includes clericals). We are in the process of preparing 19 more special rate requests (see Attachment C, p.C-6), which will bring the workforce coverage to 61%. Attachment C is an analysis of special salary rates since FY 1981, a summary of VACO's policy on special salary rates and the Medical Center's policy - Center Memorandum 05-49.

The preparation of these special rate requests is a time consuming process. The total preparation and implementation time required by logistical elements involved is from 85 hours for a position with an incumbent to an average of 240 hours for a request covering a large number of incumbents (RN's, LPN's, NR's). The average hours involved in the preparation and implementation of the twenty positions now on special rates is 108 hours (2160) hours altogether - the equivalent of one FTE annually. Attachment D is an analysis of time required for special rate requests.

These special rates have to be reviewed annually, each review takes almost as much time as the original request. As the number of positions on special rates increases, the review time will become a major staff problem.

Of special concern is the employment situation for Nursing Service staff. Here the present problem is Licensed Practical Nurses (LPN's) where we have 53 vacancies. We have had to fill these positions with Nursing Assistants. The LPN works at a somewhat higher level and can administer medications, ideally the LPN is preferable. We have had special salary rates for LPN's since October 1983 with the last salary increase in September 1988. There are few experienced LPN's in the labor market seeking employment. There are many employment opportunities for LPN's on Long Island in Nursing Homes, which pay well and have somewhat more attractive working conditions.

We currently have a Registered Nurse ceiling (FTE) of 329.1, we have 332.6 on duty. We have had special rates for Registered Nurses (RN's) since June 1984 with the most recent increase in September 1988. There are needs for RN's in several specialties such as Head Nurses, Gerontology Nurses and Oncology Nurses; however, on the whole, the situation with RN's is better than in recent years.

In February 1989, we received special salary rates for Nursing Assistants (NA's). This was followed with an advertising campaign. The results have been excellent and we have been able to recruit experienced NA's. For the first time in recent years we have more applicants (applicant supply file) than we have positions. WE have 171.8 FTE on board against an authorized FTE for NA's of 113.4. As noted above, many are filling LPN slots.

Recognizing the need for LPN's, Northport used some resources to establish an accredited LPN course on our grounds in September, 1987. Using an upward mobility concept, we selected employees with skills that were necessary to be able to successfully complete the course. This past spring, we graduated our first class of nineteen (19). The employees will receive their certification after passing the required state exam. It is planned to initiate another class this fall if resources are available.

ATTACHMENT A

HISTORY OF SPECIAL RATES FOR CLERICALS

Since the early 1980's Northport has been considered by Central Office to be in a separate communting area from the New York City VAMC's for purposes of obtaining special salary rate packages to Central Office. These document pay rates in the local community and also recruitment and retention problems relate to pay.

In June of 1987 Northport submitted a request to Central Office (similar to the City VAMC's) which would have covered all GS-2 thru GS-5 Clerk Typist and Clerk Steno positions, as well as other clerical jobs involving typing and stenography in their title. This initial request was somewhat limited in the number of positions covered. Roughly two months later the Medical Center was informed by Central Office that any request for clerical rates would need to be coordinated by Internal Revenue Service, the largest federal employer of clericals on Long Island. To get an appreciation of what this involved, consider that besides VA and IRS, other local federal employers include the Secret Service, the Alcohol, Tobacco and Fire Arms Bureau, the FAA, the Merchant Marine Academy, the Defense Logistics Agency, the Defense Investigative Services, the Defense Contract Auditing Agency, the Defense Criminal Investigative Service, the United States Army, the United States Air Force and the United States Navy.

IRS, as the Lead Agency, held meetings of representatives from all these agencies to put together data which would cover 63 clerical/administrative job series in grades 2 through 8. Twenty-seven of the 63 job series are currently in use at Northport. As you can see, the package wound up to be considerably more comprehensive in its coverage than what Northport had originally requested from CO in June.

Our response to IRS took approximately 2 1/2 months to compelte. By June of 1988 both VA and IRS had forwarded packages to higher levels to certify that there was money available. In our case, Central Office certified the submission in August of 1988.

From August until the present time, the request has been in various stages of review by Internal Revenue Service National Office and the Treasury Department. (IRS is part of Treasury).

In April 1989, IRS advised Congressman Mrazek that they are proposing forwarding the request to the Department of the Treasury with an indication that their current budget makes it impossible for the IRS to participate. This would allow submission of the package to OPM. We do not know the status of IRS's proposal at this time.

VAMC NORTHPORT

THE FOLLOWING POSITIONS IN THE GRADE RANGE GS-2 THROUGH GS-8 ARE COVERED BY REQUEST FOR SPECIAL RATES FOR CLERICAL EMPLOYEES.

GS-203	Personnel Clerical and Assistant
GS-303	Miscellaneous Clerk and Assistant
GS-305	Mail and File
GS-312	Clerk-Stenographer and Reporter
GS-318	Secretary
GS-322	Clerk Typist
GS-332	Computer Operation
GS-335	Computer Clerk and Assistant
GS-344	Management Clerical and Assistant
GS-350	Equipment Operator
GS-356	Data Transcriber
GS-382	Telephone Operating
GS-392	General Communications
GS-503	Financial Clerical and Assistant
GS-525	Accounting Technician
GS-530	Cash Processing
GS-540	Voucher Examining
GS-544	Payroll
GS-675	Medical Record Technician
GS-679	Medical Clerk
GS-998	Claims Clerk
GS-1001	General Arts and Information
GS-1105	Puchasing
GS-1411	Library Technician
GS-1531	Statistical Assistant
GS-2005	Supply Clerk and Technician
GS-2132	Travel Clerk

CLERICAL SPECIAL SALARY RATES

6/30/87	Northport submitted package to VACO for Clerk-Typist, Clerk-Steno and Paranthetical Typing and Steno positions
8/87	VACO notified us that we must submit our request through Holtsville, since IRS had been designated the "Lead" agency for clerical positions in Nassau/Suffolk Counties
8/87-10/87	Verbally tried to contact IRS several times. They were unsure as to how to proceed
10/28/87	Northport sent a letter to IRS requesting coordination since IRS still had not acknowledged that they were the "Lead" agency
11/30/87	Northport submitted to IRS a xerox of our 10/28/87 letter since IRS advised that they had not received the original letter
2/8/88	Letter from IRS received - scheduled meeting on 2/26/88 for all Nassau/Suffolk Federal Agencies
4/21/88	Package sent simultaneously to VACO and IRS. VACO to evaluate and certify to IRS that funds will be available to cover increase
6/3/88	IRS forwarded package to their Regional Office
7/21/88	VACO consortium approved package
8/1/88	Letter of certification mailed from VACO to IRS
8/23/88	Package sent from IRS Regional Office to IRS National Office in Washington
12/12/88	Package in Treasury Department for evaluation
12/29/88	VACO advised us that package had been bounced back to IRS National Office by Treasury
1/6/89	IRS advised us that the package had been returned again to the Treasury Department
2/9/89	IRS advised us that the package is still in the Treasury Department
3/15/89	IRS advised us that the IRS Regional Commissioner should be making a decision within the next several weeks regarding the inclusion of IRS in the package.
4/19/89	The IRS advised Congressman Mrazek that they are proposing forwarding the request, for which they are the lead agency, to the Department of the Treasury with an indication that their current budget situation makes it impossible for IRS to participate. This would allow submission of the package to OPM for the benefit of the other agencies included in the request.

ATTACHMENT B

SALARY FOR SELECTED ADMINISTRATIVE AND CLINICAL POSITIONS

1. The following is a comparison of VAMC Northport's salaries with the salaries of non-profit hospitalmembers of the Nassau-Suffolk Hospital Association. The survey was taken in October 1989, and is the latest information available.

VA TITLE	VAMC* NORTHPORT	RANK	COMMUNITY HIGH SALARY	COMMUNITY LOW SALARY
CHIEF FISCAL SVC	60,344	14	120,000	57,000
ASST. CH FISCAL SVC	48,152	10	90,000	37,700
CHIEF NURSING SVC	54,907	12	95,000	47,000
ASSOC. CH NURSING SVC	40,818	17	66,000	40,195
CHIEF PERSONNEL SVC	58,617	9	69,000	40,034
ASST. CH PERSONNEL SVC	51,354	2	51,500	35,000
CHIEF SUPPLY SVC	45,189	12	37,245	54,080
DIR PUBLIC REL (HSS)	42,135	11	75,000	29,000
CHIEF VOLUNTARY SVC	39,860	3	40,969	25,000
SUPV PHYSICAL THERAPY	39,856	14	56,300	35,269
REG RESPIRATORY THERAPY	33,514	19	50,000	32,550
CHIEF PHARMACY SVC	40,818	20	75,000	40,818
CHIEF SOCIAL WORK SVC	57,832	2	75,000	30,757
CHIEF ENGINEERING SVC	60,683	8	80,000	41,835
CHIEF MED ADMIN SVC	45,452	3	60,000	31,000
MEDICAL RECORD LIBRARIAN	30,488	19	65,000	29,225
CHIEF BUILDING MGMT SVC	43,452	7	65,000	31,181
CHIEF DIETETIC SVC	43,452	9	65,000	31,000
CHIEF POLICE SVC	26,727	14	55,000	15,181

* SURVEY OCT 1, 1988

4.1% INCREASE JAN 1, 1989

ATTACHMENT B -2-

2. The following is a comparison of salaries at VAMC, Northport and University Hospital, Suny-Stoney Brook. The two government operated facilities are comparable.

VA TITLE	VAMC* NORTHPORT	UNIVERSITY HOSPITAL SUNY-STONEY BROOK
CHIEF FISCAL SVC	60,344	79,000
ASST. CH FISCAL SVC	48,152	63,000
CHIEF NURSING SVC	54,907	54,000
ASSOC. CH NURSING SVC	40,818	66,000
CHIEF PERSONNEL SVC	58,617	65,000
ASST. CH PERSONNEL SVC	51,354	43,000
CHIEF SUPPLY SVC	45,189	46,000
DIR PUBLIC REL (HSS)	42,135	43,000
CHIEF VOLUNTARY SVC	39,860	38,000
SUPV PHYSICAL THERAPY	39,856	51,000
REG RESPIRATORY THERAPY	33,514	50,000
CHIEF, PHARMACY SVC	40,818	52,000
CHIEF SOCIAL WORK SVC	57,832	50,000
CHIEF ENGINEERING SVC	60,683	—
CHIEF MED ADMIN SVC	45,452	60,000
MEDICAL RECORD LIBRARIAN	30,488	52,000
CHIEF BUILDING MGMT SVC	47,405	43,000
CHIEF DIETETIC SVC	43,452	43,000
CHIEF POLICE SVC	26,727	—

* SURVEY OCT 1, 1988

4.1% INCREASE JAN 1, 1989

ATTACHMENT C

SPECIAL SALARY RATE DATA

(1981 - 1985)

5/1/89

SPECIAL RATE POSITIONS	RATES IN EFFECT PRIOR TO 1981	EFFECTIVE DATES OF NEW RATES OR RATE CHANGES						
		1981	1982	1983	1984	1985		
EEG Technician						2/17/85 (NEW)		
Engineers	10/13/74	NATIONWIDE SURVEY CONDUCTED BY OPM						
Licensed Practical Nurse	2/6/72	1/11/81 & 10/4/81 DECREASE	10/3/82 INCREASE	10/2/83 INCREASE	NO CHANGE	NO CHANGE		
Occupational Therapist	2/6/72	1/11/81& 10/4/81 INCREASE	10/3/82 INCREASE	10/2/83 INCREASE	1/8/84 INCREASE	NO CHANGE		
Pharmacist						11/24/85 NEW		
Physical Therapist	2/6/72	10/4/81 DECREASE	4/18/82 INCREASE	10/2/83 INCREASE	1/8/84 DECREASE	3/17/85 INCREASE		
Police Officer				10/2/83 NEW	10/1/84 INCREASE	NO CHANGE		
Radiology Technician (Diagnostic)	1/7/73	1/11/81 INCREASE 10/4/81 DECREASE	4/18/82 INCREASE 10/3/82 INCREASE	10/2/83 INCREASE	NO CHANGE	1/6/85 DECREASE		
Radiology Technician (Therapeutic)						9/1/85 NEW		
Registered Nurse	1/10/71 ABOVE MINIMUM	6/14/81 ABOVE MINIMUM	10/3/82 ABOVE MINIMUM	NO CHANGE	1/8/84 ABOVE MINIMUM	1/6/85 ABOVE MINIMUM		
Respiratory Therapist	2/6/72	10/4/81 DECREASE	4/18/82 INCREASE	10/2/83 INCREASE	NO CHANGE	NO CHANGE		
							C-1	

EXISTING STOCKS OF VA FORM 7051d, JUL [illegible], WILL BE USED.

SPECIAL SALARY RATE DATA
(1986)

5/1/89

SPECIAL SALARY RATE POSITION	DATE 05 BEGAN WORK	DATE, TO MANAGEMENT	DATE TO VACO	DATE APPROVED BY VACO	FUNDS REQUESTED FROM VACO	FUNDS APPROVED BY VACO		
EEG Technician	-	10-22-86	10-24-86	Disapproved 03-13-87	-	-		
Engineering	NATIONAL SURVEY CONDUCTED BY OPM			-	-	-		
Licensed Practical Nurse	-	11-21-86	11-25-86	02-15-87	-	-		
Nuclear Medicine Technician	- -	01-17-86 10-22-86	01-23-86 10-24-86	04-13-86 04-12-87	- -	$1500		
Occupational Therapist	-	10-22-86	10-24-86	04-12-87	-	$30,470		
Pharmacist	-	-	07-16-86	12-07-86	-	-		
Physical Therapist	-	06-30-86	07-03-86	12-07-86	-	-		
Police Officer	-	03-07-86	03-10-86	09-28-86	-	-		
Radiology Technician (Diagnostic)	-	10-22-86	10-24-86	04-12-87	-	$36,694		
Radiology Technician (Therapeutic)	-	10-22-86	10-24-86	05-10-87	-	-		
Registered Nurse	-	-	11-21-86	02-15-87	-	-		
Respiratory Therapist (Certified)	-	-	04-30-86	08-03-86	-	-		
Respiratory Therapist (Registered)	-	-	04-30-86	08-03-86	-	-		
							C-2	

VA FORM MAY 1953 7051d **DATA SHEET** EXISTING STOCKS OF VA FORM [illegible], JUL. [illegible], WILL BE USED.

SPECIAL SALARY RATE DATA
(1987)

5/1/89

SPECIAL RATE POSITION	DATE 05 BEGAN WORK	DATE TO MANAGEMENT	DATE TO VACO	DATE APPROVED BY VACO	FUNDS REQUESTED FROM VACO	FUNDS APPROVED BY VACO		
EEG TECH.	—	SURVEY NOT REQUIRED						
ENGINEERING	—	NATIONWIDE SURVEY CONDUCTED BY OPM						
LICENSED PRACTICAL NURSE	—	6/25/87	6/30/87	8/16/87	$795,000	$184,585		
NUCLEAR MEDICINE TECH	—	SURVEY NOT REQUIRED						
OCCUPATIONAL THERAPIST	—	SURVEY NOT REQUIRED						
PHARMACIST	---	8/19/87	10/8/87 * 8/24/87	1/17/88	$109,648	$99,630		
PHARMACY TECH	—	6/25/87	6/30/87	6/19/88	$59,000	—		
PHYSICAL THER	—	8/19/87	8/24/87	10/25/87	$26,133	$26,822		
POLICE OFFICER	—	SURVEY NOT REQUIRED						
RADIO TECH (DIAG)	—	SURVEY NOT REQUIRED						
RADIO TECH (THER)	—	SURVEY NOT REQUIRED						
REGISTERED NURSE	—	7/31/87	8/3/87	8/30/87	$125,590 (87) $1,507,134 (88)	$162,933 (87) 1,507,437(88)		
RESP. THER (CERT)	—	8/19/87	8/24/87	12/20/87	$73,183	$50,244		
RESP. THER (REG)	—	8/19/87	8/24/87	12/20/87				
*ADDITIONAL DATA SUBMITTED							C-3	

VA FORM MAY [illegible] 7051d **DATA SHEET** EXISTING STOCKS OF VA FORM [illegible], JUL [illegible], WILL BE USED.

SPECIAL SALARY RATE DATA
(1988)

5/1/89

SPECIAL RATE POSITION	DATE 05 BEGAN WORK	DATE TO MANAGEMENT	DATE TO VACO	DATE APPROVED BY VACO	FUNDS REQUESTED FROM VACO	FUNDS APPROVED BY VACO		
Accountant	New York City Metropolitan Area Survey Conducted by OPM							
Dietetic Technician	04-01-88	11-30-88	12-05-88	04-09-89	$20,230	$18,312		
EEG Technician	01-06-88	-	02-23-88	Disapproved 11-30-88	$ 5,400	-		
Engineering	National Survey Conducted by OPM							
Licensed Practical Nurse	04-15-88	07-19-88	07-27-88	09-11-88	$256,749	$912,415('88) $303,061('89)		
Nuclear Medicine Technician	05-01-88	-	07-01-88	12-18-88	-	$3,050		
Nursing Assistant	05-07-88	07-19-88	08-02-88	02-12-89	$863,732	$661,036		
Occupational Therapist	06-20-88	11-09-88	11-22-88	04-09-89	-	$ 63,120('88) $ 4,524('89)		
Pharmacist	01-20-88	07-19-88	08-01-88	01-01-89	$266,396	$187,711		
Pharmacy Technician	06-30-87	Survey Not Required		-	-	-		
Physical Therapist	06-15-88	11-09-88	11-22-88	Still Pending	-	-		
Physician Assistant	06-30-88	11-30-88	12-05-88	04-09-89	$ 74,953	$ 62,180		
Police Officer	01-10-88	03-01-88	03-07-88	01-29-89	-	-		
Radiology Technician (Diagnostic)	06-20-88	11-09-88	11-22-88	04-09-89	-	$ 71,400('88) $ 54,682('89)		
Radiology Technician (Therapeutic)	02-17-88	-	03-09-88	06-19-88	-	-		
Registered Nurse	04-14-88	06-06-88	06-08-88	09-11-88	$1,457,500	$1,017,942		
Respiratory Therapist	07-25-88	11-09-88	11-22-88	04-09-89	-	$ 60,128		
Respiratory Therapist (Certified)	08-01-88	11-09-88	11-22-88	03-26-89	-	$ 9,184		
Respiratory Therapist (Registered)	08-01-88	11-09-88	11-22-88	03-26-89	-	$ 18,614		
Ultrasound Technician	02-15-88	-	03-18-88	07-31-88	-	-	C-4	

VA FORM MAY 1933 7051d DATA SHEET EXISTING STOCKS OF VA FORM [illegible], JUL [illegible], WILL BE USED.

SPECIAL SALARY RATE REQUESTS PENDING IN VACO

5/1/89

POSITION	DATE OS BEGAN WORK	DATE TO MANAGEMENT	DATE TO VACO	DATE APPROVED BY VACO	FUNDS REQUESTED FROM VACO	FUNDS APPROVED BY VACO		
Alcohol Rehabilitation Technician	8/7/88	11/9/88	11/22/88	—	—	—		
Cardiac Catheterization Technician	2/22/89	3/21/89	3/24/89	—	$ 7,248	—		
Cleric.l Positions	2/8/88	—	4/21/88	—	1,129,000	—		
Creative Arts Therapist	3/31/89	4/10/89	4/12/89	—	8,864	—		
Medical Machine Technician	2/22/89	3/21/89	3/24/89	—	7,978	—		
Medical Record Librarian	9/27/88	11/9/88	11/22/88	—	—	—		
Medical Technician	9/20/88	11/30/88	12/2/88	—	133,345	—		
Medical Technologist	9/20/88	11/30/88	12/2/88	—	149,294	—		
Physical Therapist	6/15/88	11/9/88	11/22/88	—	—	—		
Physicist	2/15/89	3/21/89	3/24/89	—	55,032	—		
Recreational Therapist	3/31/89	4/10/89	4/12/89		27,039	—		
Social Worker	8/8/88	11/30/88	12/5/88	—	289,353	—		

C-5

VA FORM 7051d DATA SHEET
MAY 1953

EXISTING STOCKS OF VA FORM [illegible], JUL [illegible], WILL BE USED.

SPECIAL SALARY RATE SURVEYS PENDING AT NORTHPORT

5/1/89

AUDIOLOGY & SPEECH PATHOLOGIST

CHAPLAIN

COMPUTER SPECIALIST

DENTAL LAB AID/TECHNICIAN

DIETITIAN

HEALTH SYSTEM SPECIALIST

HEMODIALYSIS TECH.

HOSPITAL HOUSEKEEPING MANAGEMENT

ILLUSTRATOR

INDUSTRIAL HYGIENIST

INSTRUCTIONAL SYSTEMS SPECIALIST

MANUAL ARTS THERAPIST

MEDICAL SUPPLY TECHNICIAN

ORTHOTIST/PROSTHETIST

PSYCHOLOGIST

PSYCHOLOGY TECHNICIAN

PURCHASING AGENT

REHABILITATION THERAPY ASST.

SOCIAL WORK ASSOCIATE

ATTACHMENT D

TIME ANALYSIS - SPECIAL SALARY RATE REQUESTS

I. Average Time to Complete Request Process for Positions Currently Covered (based on 17 regular size and 3 large size occupation series)

A. 1. Service - 23 hours
Includes: identifying recruitment and turnover, compiling salary comparison data, preparing memorandum with narrative justification

2. Personnel Specialist - 23 hours
Includes: review and verification of recruitment and turnover data, resolving discrepancies, writing narrative justification, spot-checking salary comparison data.

3. Typing - 4 hours

4. Telephone Contacts - 3.45 hours
Includes: contacts with other local hospitals, other VAMC's, service, VACO

5. Briefing - 1.15 hours
Includes: transmitting E-mail messages, fielding questions from staff

6. Review - 2 hours
Includes: review and signature by Personnel Officer, Chief of Staff, Associate Director and Director

B. Time to Implement Approved Rates in Personnel Service - 17 hours
Includes: preparing pay scale, memorandum to affected employees, letter to the Office of Personnel Management, identifying affected employees, coding and review of VAF 4652's for each affected employee, entering action into computerized personnel actions file.

C. Time to Implement Approved Rates in Fiscal Service - 29 hours
Includes: review of coded VAF 4652's, manual adjustments to payroll, retroactive adjustments

D. Time to Provide Data to Management - ½ hour

E. Follow-up - 4.7 hours
Includes: review of 4652 against SF-50 and taking corrective action when necessary.

F. TOTAL - 108 HOURS FROM REQUEST THRU IMPLEMENTATION OF RATES

II. Average Time to Complete Annual Review Process for Positions Currently Covered

Breakdown and total is same as I. above.

I. Average Time to Complete Request Process for Large Size Occupation Series (based on 200 employees per occupation series)

A. 1. Service - 40 hours
Includes: identifying recruitment and turnover, compiling salary comparison data, preparing memorandum with narrative justification

2. Personnel Specialist - 40 hours
Includes: review and verification of recruitment and turnover data, resolving discrepancies, writing narrative justification, spot-checking salary comparison data.

3. Typing - 4 hours

4. Telephone Contacts - 6 hours
Includes: contacts with other local hospitals, other VAMC's, service, VACO

5. Briefing - 2 hours
Includes: transmitting E-mail messages, fielding questions from staff

6. Review - 2 hours
Includes: review and signature by Personnel Officer, Chief of Staff, Associate Director and Director

B. Time to Implement Approved Rates in Personnel Service - 45 hours
Includes: preparing pay scale, memorandum to affected employees, letter to the Office of Personnel Management, identifying affected employees, coding and review of VAF 4652's for each affected employee, entering action into computerized personnel actions file.

C. Time to Implement Approved Rates in Fiscal Service - 80 hours
Includes: review of coded VAF 4652's, manual adjustments to payroll, retroactive adjustments

D. Time to Provide Data to Management - ½ hour

E. Follow-up - 20 hours
Includes: review of 4652 against SF-50 and taking corrective action when necessary.

F. TOTAL - 239.5 HOURS FROM REQUEST THRU IMPLEMENTATION OF RATES

II. Average Time to Complete Annual Review Process for Large Size Occupation Series

Breakdown and total is same as I. above.

TIME ANALYSIS - SPECIAL SALARY RATE REQUESTS

I. Average Time to Complete Request Process for Regular Size Occupation Series (based on 20 ~~employees per~~ occupation series)

A. 1. Service - 20 hours
Includes: identifying recruitment and turnover, compiling salary comparison data, preparing memorandum with narrative justification

2. Personnel Specialist - 20 hours
Includes: review and verification of recruitment and turnover data, resolving discrepancies, writing narrative justification, spot-checking salary comparison data.

3. Typing - 4 hours

4. Telephone Contacts - 3 hours
Includes: contacts with other local hospitals, other VAMC's, service, VACO

5. Briefing - 1 hour
Includes: transmitting E-mail messages, fielding questions from staff

6. Review - 2 hours
Includes: review and signature by Personnel Officer, Chief of Staff, Associate Director and Director

B. Time to Implement Approved Rates in Personnel Service - 12 hours
Includes: preparing pay scale, memorandum to affected employees, letter to the Office of Personnel Management, identifying affected employees, coding and review of VAF 4652's for each affected employee, entering actions into computerized personnel actions file.

C. Time to Implement Approved Rates in Fiscal Service - 20 hours
Includes: review of coded VAF 4652's, manual adjustment to payroll, retroactive adjustments

D. Time to Provide Data to Management - ½ hour

E. Follow-up - 2 hours
Includes: review of 4652 against SF-50 and taking corrective action when necessary.

F. TOTAL - 84.5 HOURS FROM REQUEST THRU IMPLEMENTATION OF RATES

II. Average Time to Complete Annual Review Process for Regular Size Occupation Series

Breakdown and total is same as I. above.

STATEMENT OF MR. GREGORY J. HAAG
DIRECTOR, HEALTH CARE STAFF DEVELOPMENT AND RETENTION

I am pleased to provide a statement for the field hearing to be conducted at Northport, NY, DVA Medical Center on May 15, 1989.

In January of 1987, Dr. Gronvall commissioned a task force on recruitment and retention of non-physician health care workers. This task force completed its work in the fall of 1987 with 27 recommendations to the Chief Medical Director. These recommendations included the establishment of a program office to oversee the implementation of the recommendations and provide a focal point for recruitment and retention activities for the non-physician Title 38 health care providers. This office, titled Health Care Staff Development and Retention, was approved in late 1988 and began operation in January of 1989. I was pleased to be appointed the director of this activity. The recommendations, which were categorized into four areas of concern as follows: (a) Management Issues, (b) Benefits, (c) Image, (d) Salary.

These recommendations of the task force were based on input from multi-disciplinary groups, the majority of which were from the field and were constantly in touch with the activities of their peers within the private sector. Many of the task force recommendations are currently under active review and specific proposals are being developed.

While formal data are not available on how deteriorating funding has affected morale, I feel that our recruitment and retention problems are in fact affecting morale (need to work overtime, working side-by-side with higher paid contract employees, etc.). This has been expressed by employee organizations and facility managers.

Since I have assumed the position of the Director, Health Care Staff Development and Retention, I have made numerous visits to medical centers and met personally with staff nurses and head nurses. In every instance of discussions with staff nurses it is their perception that when times get tough that Nursing Service is expected to take up the slack in the shortage of supportive activities. For example, if respiratory therapy becomes short of staff, the nurses provide the treatments needed. When Pharmacy becomes short of staff, more than likely they will close satellite pharmacies or eliminate tour coverage, requiring nurses to pursue the acquisition of needed medications through more difficult processes. Likewise, when administrative support becomes short, the required adminiatrtive functions are expected to be performed by the nursing personnel. The only relief that nursing may experience is the reduction of beds under their responsibility. Consequently, their perception is that Nursing Service and nurses, specifically, are expected to take up the slack when funding is reduced for support services. This aggravates an already poor patient to nurse staff ratio. Nurse recruiters repeatedly indicate that one of the first questions that a nurse applicant asks is the patient to nurse ratio. In many cases the conversation and the interview of an applicant stops at that-point.

Similar types of comments are made by the support personnel indicated above that they can only stretch their work for so far and when there is not the manpower to go around they simply can not provide the services requested and needed for direct patient care.

The following actions have been initiated in an effort to address the recruitment and retention problems:

- The third annual survey of health occupational staff is underway. The data should be available soon. This data, along with data from a survey of all medical center's conducted by my office will be used to assist in the development of a tracking system of critical health occupations. This data will be compared with on-duty FTEE information from the PAID system. The information derived from this comparison will be used to identify trouble spots on a station by station basis as well as by discipline, and provide current nationwide figures.

- We are in the process of implementing an image enhancement program to improve our perception as a preferred health care employer. This campaign will initially focus on efforts to improve the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other scarce occupations.

- One phase of the image campaign has begun with a new attention getting look at our exhibit booths at national professional meetings. A laptop computer containing information on pay schedules for nurses, nurse anesthetists and pharmacists for individual medical centers has been tested at two meetings. The computer will provide a printout of this information, along with federal employment benefits, for the interested meeting participant. This computer, along with photo buttons identifying the VA, has been very successful in attracting meeting participants to the exhibition booth.

- A VA Task Force recently convened in February 1989 to examine the current Title 38 pay system for nurses and to develop strategies for improvements in both the administrative and legislative arenas.

- Also, we are in the process of pursuing the following established under Public Law 100-322, "Veterans' Benefits and Services Act of 1988":

  o Saturday Premium Pay for registered nurses;

  o Tuition reimbursement for those employees pursuing nursing degrees;

  o Study of various alternative pay, personnel management, and benefit practices in the interest of improving our competitive recruitment and retention stance;

  o Child care center operation at VA facilities;

  o Health Care Professional Scholarship Program expansion;

  o Conversion of pharmacists and occupational therapists under "hybrid Title 38".

- A variety of regional and local initiatives are being monitored throughout the system. These efforts will be formalized into a clearinghouse function that will serve to ensure the broadest dissemination.

EDWARD E. FISCHEL, M.D.
Chief of Staff

Proposed Testimony for Congressional Hearing at VAMC/Northport on May 15, 1989

My name is Edward Fischel. I am a physician, the Chief of Staff at the VA Medical Center at Northport NY since 1983. I am also Associate Dean for Veterans Affairs and Professor of Medicine, School of Medicine of the State University of New York at Stony Brook.

I came to the VA after this facility had already undergone a transition from being the largest psychiatric hospital in the VA system to a mixed acute medical, surgical and psychiatric hospital.

In the 1970's, a deinstitutionalization program had been initiated with the establishment of eight satellite clinics on Long Island. About 2000 veteran patients with psychiatric disorders were discharged to foster care and adult homes.

This program was probably the most successful deinstitutional program in the nation and resulted in very few of the problems which the state and county deinstitutionalization programs have experienced. Our patients have been followed regularly. They are growing older and many have multiple medical disorders which we try to address. A few hundred of the more severely ill patients could not be out-placed at that time and the residue of that group, about 125 patients, remain as a long term chronic care component of our medical center.

In 1972 a new acute hospital was completed to care for the acute medical and surgical problems of the veteran population of Long Island and also to participate in the educational and research programs of the newly erected School of Medicine at SUNY/Stony Brook.

Various demographic studies have indicated that the veteran population on Long Island constitutes the largest concentration of veterans surrounding any single VA hospital in the nation.

Over the past five years, with the budgetary constraints, the problems peculiar to our location have been manifest. Travel to and from the hospital for our patients is difficult since public transportation on Long Island is very diffuse and costly. As Mr. Manley has indicated to you, our ability to recruit and retain employees at all levels has also felt the impact of the expense of housing, of transportation, as well as the real estate and state income tax situation. There is a very high cost of services and goods. In the award for special-pay for nurses, this area was recognized as having the highest cost of living on the East Coast, comparable only to three other areas in the country - Los Angeles, San Francisco and San Diego. Obviously for many technical and non-technical positions, we compete poorly with many hospitals, industries and local government positions in the immediate area.

Other areas -

Resident training program - In March 1989 VACO ordered a cut of at least one resident in each teaching hospital, despite contractual commitments several months previously. Career upheavals, possible litigation and lack of credibility in the VA are obvious impacts of this perhaps necessary but poorly timed action.

Difficulties in recruiting and retaining personnel in this high cost area have been encountered in many clinical and non-clinical support areas. Delays have resulted in negative effects on work load, quality assurance programs and on employee morale.

In Medicine, long delays occurred in filling needs for an infectious disease specialist, and for the strategic functioning of the Evaluation and Treatment Area, our emergency and admissions area. The recommendations of the New York State Department of Health for limited hours for residents and more involvement by supervisors has had a pronounced negative effect on the staffing of the ETA. Physicians interested and capable in this area are being wooed by numerous hospitals in the State, with phenomenally escalating salaries and benefits. The likelihood of meeting our veterans' needs and at the same time, the regulations of the State of New York appear uncertain at best.

Among the other programs for which recruiting has been impossible are Gynecology (with the growing need to care for women veterans) and Rehabilitation. In the latter instance, search for a Chief in conjunction with our affiliated School of Medicine was unsuccessful several years ago despite the attraction of the excellent facilities and personnel available. This facility won the designation of a "Comprehensive Rehabilitation Center" awarded competitively from VACO in 1983. Fortunately, our Chief of Orthopedic Surgery was interested in the challenge of a good rehabilitation service and consented to head up that service as well as his own area.

Additional problems in recruiting leadership positions have also existed in:

Dermatology
Plastic Surgery
Radiotherapy
Otolaryngology (ENT)
Cardiology
Gastroenterology

In the midst of these difficulties, the medical center was suddenly confronted with the need to increase our efforts with no increase in resources when the Benefits section of the VA decentralized the Compensation and Pension examinations. Our work load suddenly increased from approximately 30 to 180 examinations per month, with long delays for already heavily booked clinics. An experienced C&P physician has been recruited on a half time basis to facilitate the process.

Among the most obvious impacts of the budgetary constraints of the past several years is the deterioration of regularly used and basic medical equipment. Existing electrocardiographic machines are outmoded after many years of use as are many ventilators in respiratory therapy and anesthesiology. For FY 86 to FY 88 our budget allocations for replacement and additional equipment was a total of $594,103; $663,450; and $542,278. For FY 89, the reduced budget is for $333,404. Our Acquisition and Material Management Service (Supply Service) estimates that many smaller clinical instruments require replacement for a total of 2.5 to 3 million dollars. Examining tables, stretchers, wheel chairs and Gerry chairs add to this list. Newer types of beds - Clinitron or Kinaire beds are costly but necessary for debilitated patients who may develop bed sores which can be prevented or brought to a treatable stage.

There is a lack of major equipment that is rapidly becoming available and customary at many community hospitals. To serve our large veteran population these are needed.

In 1982 we inherited a used Cobalt Unit that had been declared excess when the VAMC/Bronx received its state-of-the-art Linear Accelerator for the treatment of cancer. We have maintained and refurbished that Cobalt Unit although it is no longer acceptable for most cancers. Our cancer patients have had to travel the long and wearing journey into the Bronx for daily radiotherapy treatments of a course of several weeks which can increase their debility long before improvement may occur. We recently have completed a sharing agreement with our affiliated Medical School for treatment by their Linear Accelerator. The costs for this are considerable and not readily offset. With our aging population, cancer has become an unhappily frequent occurrence and on-site modern equipment is needed.

I appreciate this opportunity to present a thumbnail sketch of the impact of budgetary constraints on our programs. However necessary budget cuts may appear to be, they are not without their effects. We should be mindful of that.

FIELD HEARING TESTIMONY
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
DVA MEDICAL CENTER - NORTHPORT, NEW YORK
MONDAY, MAY 15TH, 1989

My name is Thomas S. Cottrell. I am a physician on the faculty of the School of Medicine, State University of New York at Stony Brook and I serve as the Executive Associate Dean of the School of Medicine, and as a member of the Dean's Committee. There has been an affiliation agreement between the School and the Veteran's Administration Medical Center at Northport since 1974

I wish to address the issue of the effect of budget constraints on the delivery of quality health care to veteran patients and in particular the relation of these constraints to recruitment and retention of medical staff and the resulting threat to the quality of care from the point of view of an affiliated medical school. I will be brief.

I would like to read from a letter addressed to the Chairman of Deans Committees in affiliated V.A. hospitals from Donald Custis, M.D., Chief Medical Director of the Department of Medicine and Surgery of the Veteran's Administration dated 20 October 1980. The letter is about the shared responsibility that has characterized the affiliation between medical schools and V.A. medical centers since 1946. I quote, " The 'methods' which have evolved in the ensuing 35 years are well known. Affiliated medical schools have assisted in the recruitment of talented clinicians and investigators who provide the highest obtainable quality of care to veteran patients, and at the same time serve the medical schools as respected faculty and contributors to scholarly research and clinical investigation."

I have great concern that the budget problems that are the topic of this hearing pose a serious threat to the medical care of veterans. These constraints endanger what I believe to be the very foundation of the high quality of care that has been delivered to veterans for the last 43 years, that is the special relationship between academic medicine and the Veterans Administration, now the Department of Veterans Affairs.

The role of the medical schools described in Dr. Custis' letter cannot be carried out if the resources necessary to support their recruiting and sustaining efforts are withdrawn. The ability of the medical schools to identify, recruit, and retain talented clinicians has been the basis of a system of veterans care unequaled anywhere. Parenthetically, the special relationship of shared responsibility has led scientific excellence as well, as I am sure you all recall a recent Nobel Prize being awarded to a medical school faculty member who was on the staff of a veterans hospital.

The Department of Veterans Affairs has a share in this mutually beneficial arrangement. It is to provide certain resources necessary for the task that the Department and the medical schools have undertaken together. If either member of this affiliation falters, the mission will fail and the veterans will suffer the consequences.

I am reminded of the couple at a party celebrating their 50th wedding anniversary. They were asked if, over their years together when things became difficult, they ever considered divorce. After a glance at one another they answered almost in unison, "No not divorce, murder maybe, but never divorce."

I hope as the affiliation program nears its 50th anniversary that short sighted budget planning and resource and limitation do not change the punch line of the story and result in harm to American veterans. We cannot do more with less. If budget constraints become grounds for divorce between the Department of Veterans Affairs and academic medicine, the veterans hospitals will not only have abandoned their mission in education and research, they will have severely limited their ability to achieve their goals in the care of the veteran patient.

Thank you.

PREPARED STATEMENT OF GEORGIANA KACHURA, NATIONAL VICE PRESIDENT, NFFE, REGION 1

My name is Georgiana Kachura and I am the National Vice President of the National Federation of Federal Employees for Region 1. The National Federation of Federal Employees represents 150,000 federal employees in 40 agencies across the country. I appreciate the opportunity to present our views on the current state of problems plaguing the health care system, including problems with recruitment and retention of health care personnel within the Veterans Administration. I am employed by the VA, work here at Northport as a RN and I am President of Local 387 NFFE.

NFFE represents employees of every occupation, both professional and non-professional, within the VA hospital system. Our members include registered nurses (RN), licensed practical nurses (LPN), doctors, dentices, pharmacists, engineers, even police officers, and firefighters to mane just a few of the positions. For the most part. these employees have served the Veterans' Administration for many years, devoting their careers to the care of this nation's veterans. With their experience and expertise, the VA's medical care personnel are without a doubt the most valuable resource the VA hospitals have.

During the past few years we have witnessed a growing problem with the recruitment and retention of these personnel, particularly within the field of direct patient care. And unfortunately, this comes at a time of increasing demands on the VA hospital system. As the nation's veteran population ages, they require greater care which means the allocation of more resources to each patient. This includes both technology and direct patient care. But as the committee well knows, the Veteran's Administration has been unable to recruit or retain the necessary staff.

We cannot point to just one or two causes for the high attrition and recruitment problems which the agency is currently experiencing. We believe, instead, that the difficulty stems from a series of crises'.Proposed and actual budget cuts have severly reduced resources and damaged morale.

The National Commission on the Public Service's study of the federal service says Americans will feel the effects of 12 years of budget cuts in the next decade. But the effects of Fed bashing, low pay and poor working conditions are already here.

It used to be that American veterans received the best care and benefits in the world. A study of a typical VA hospital like Northport however, reveals a string of horrors caused by budget ans staff cutbacks. Our veterans are losing out.

The VA needs increased funding for the medical system. Without additional resources VA hospitals will not remain competitive with private sector facilities in hiring quality personnel. We also believe that many of the VA's staffing problems are rooted in their outdated and their generally inequitable personnel system. Many VA medical personnel are covered under Title 38 instead of the provisions of Title 5 which cover the rest of the civilian workforce. For example, these medical personnel are not promoted nor are they disciplined in the same manner as their civil service coworkers. Instead, they must submit to highly subjective Peer Review Boards or Disciplinary Boards which often deny employees adequate review or due process. Lacking objectivity and crediblity, these Boards are the proverbial "straw that breaks the camel's back". If the lower pay or less generous benefits don't drive employees away, the VA personnel system is frequently the final straw.

The National Federation of Federal Employees represents medical personnel in Veterans Hospitals throughtout the nation. And we are aware of staffing problems of varying degrees in each of these facilities. Whether the hard-to-fill occupation is a registered nurse, pharmacist, or critical care nurse, there is one factor common to all: the VA's compensation and personnel policies have not given the agency the resources to remain competitive in its hiring practices.

Veterans entering this prticular hospital should expect only minimal care. The overworked nursing department is loaded down with chores from SEVEN departments which have been cut back or eliminated altogether. While caring for patients, nurses must also find and deliver their own supplies, find, sort, and deliver laundry, intervene in crises, pick up and deliver lab specimens, locate and stock drugs, clean toilets and strip and make beds. When can they possibly care for patients? We say that we shouldn't be held responsible for what happens on the floor because we're absent to often doing the jobs of others.

You might be asking yourself why are RN's doing the jobs of non-professional employees? Where are these non-professional employees? What is the problem? and How does this impact on patient care, recruitment and retention? In order to answer these questions we must first examine what RN's are doing in each category.

Veterans' health and lives are endangered when nurses must leave their posts to search for medical supplies because the medical supply service has been unable to hire sufficient help. There is often no one to care for patients when nurses must leave to do the work of others. Examples are as follows:

*SPD Service (not part of NFFE Local 387) has decided discontinue service 4 p.m. to 8 a.m.
SPD is medical supply service. How are we suppose to care for patients if we do not have gloves, chux, diapers, spinal tap trays, etc? If we do not have these on the unit we are expected to find them and borrow from other units. Therefore, RN's are doing GS 3-4 jobs. Patient care is jeopardized while we run around searching for supplies.

*Lab Service (not part of NFFE Local 387) will only do certian tests on certian days.
Tests such as SMAC, routine chemical test on blood is not done on weekends. The lab will only pick up specimens at certian times during the day. It will only draw blood at certian times. Therefore RN's must do the lab's job also.
Management agreed to supply escort service but they have not. RN's in the Cardiac Care Unit and Intensive Care Unit are leaving the unit to deliver specimens. In other words, GS 9-11's are doing the job of a GS 2-3. When they leave the unit patients are cared for by a seriously depleted staff. Patients have coded and died. In addition to delivering specimens nursing is expected to leave patient care areas to do other escort services.

Escort Service is not provided.
Nurses must leave patient care areas to deliver paperwork, get morgue keys, obtain supplies, laundry, and drugs, deliver specimens and escort patients to x-ray, lab, or appointments, etc. With all this time off the unit why are we held responsible for what happens on the unit? To add insult to injury we are also expected to review policy changes on our meal breaks. In other words, we are expected to do performance of work on off-duty time.

Pharmacy Service (also not part of Local 387) is not available from 4 p.m. to 8 a.m. since they plan on discontinuing service.
What are we supposed to do if medicines are ordered that we do not have? Pharmacy is suppose to do unit dose but has discontinued this on many units, therefore RN's must stock their own med carts. Again patient care suffers while the RN is absent doing another persons job.

Many veterans must lie naked in their beds, often without sheets, because the contracted out laundry service was completely fouled up. After getting the contract out of Northport VA the hospital finds itself without sufficient supplies of linen.

> It is not a nursing function however nursing is left to sort patient clothing. Patients on psychiatric units oftengo nude because there is nothing to dress them into, not even their own clothing.

You should expect a clean, sterile environment in any hospital. Not at this VA hospital. Here, you will find roaches, dirty linen and as one nurse said, "The stench of urine would gag you." The building management department was cut back and garbage and dirty linen are not removed as often as necessary. On evenings and nights there is no building management dispite the need. Therefore nursing is left to do any necessary cleaning.

> The hospital needs building management 24 hours around the clock. The day staff is insufficient. What numbers there are to do the work in the day is insuffient. Nursing must mop floors, clean toilets, and perform other housekeeping functions because of lack of sufficient building management staff. The numbers of personnel in this department can not possibly do the amount of work required of them. It is impossible.

The hospital disbanded its psychiatric crisis team because there had only been four crises the year before. The hospital should issue warnings to incoming patients: NO EMERGANCIES PLEASE.

> When a crisis occurs on a psychiatric unit it use to be that we could call for help. The team that use to respond has been disbanded. The team is gone and nursing is left to deal with the crisis by itself. On the 4 p.m. to 12 mid. and the 12 mid to 8 a.m. shifts there are usually only 1 RN and 2 other employee to do all the care. If these three employees are dealing with the crisis, who is caring for the other 30-43 patients. How are three employees suppose to restrain and medicate the agitated patient while also caring for all the other patients.

Why are RN's who are GS 9-11 doing the non-professional GS 2-3-4-5 jobs? Simply put, there isnot enough of the non-professional employees. The work must get done or providing care becomes impossible. Budget cuts have been wide and deep in these categories. Adding to the budget cuts is the fact that you simply do not pay these employees enoough. No one would agree to come on with what you pay these employees, especially when they can do better in private sector. Think about it, you can go work for MacDonalds and if you stay at it for a few years you could be a manager of your own place.

How does this impact on patient care, recruitment and retention? The mission of the VA addresses itself to the need to provide quality care. As a RN working in the system I declare to you that quality care iss absent. Ten years of budget cuts have forced VA hospitals to gut staff structure just to make ends meet. The ends don't meet anymore and American veterans are falling through the cracks.

And they deserve better, much better. (For the record, I'm a Vietnan veteran, and I would like to use the system, but I won't). The American public deserve better. Cutbacks, low pay, RIF's, contracting out, and shortcuts are destroying the public service and depriving Americans of vital services.

During NFFE's Lobby Week '89, Representative Steny Hoyer (D-Md) told NFFE members "...If we don"t pay Federal employees a fair wage, we will be unable to retain people of your quality and the American public will be the loser. Remember, it isn't just for you, but for America.

Fed bashing, low pay, budget cuts and staff cutbacks have had a demoralizing effect on remaining employees who take less pride in their work. Pride is gone because employees are expected to do more and the impossible with lessor none. Working conditions will continue to deteriorate when pride is absent. It is like a ball rolling down a hill, it will not go up the hill unless someone or something makes it.

The VA medical system needs the support services which are severly depleted at present. The lack of these services has a direct impact on recruitment and retention. Management at this facility has requested RN's to write Reports Of Contact whenever they have to do something that is not their job. As President of Local 387 I have encouraged them to write these reports. I quote the responses I got:

> Dear Anne,
>
> CCU continues to house DNR patients and anything else that comes thru the door. We are many times short staffed and it makes no difference to anyone as far as the number of patients we serve. No one cares about safety or patient care. No one cares how much responsibility the RN takes. They just shove the patients in the door until we are fill.
>
> If there are call ins we are expected to remain no matter how tired we are, no matter how exhaused we are.
>
> Nurses are to tired to write ROC's, to busy, and in a lot of cases have just given up. A Lot of them want out! I want out!! Most of us want out of the VA! Some just want out of nursing.
>
> Frankly, the situation is so bad I hear many say, "They can't pay me enough to stay." You know what , they can't.
>
> Your friend,
> A RN in CCU

Still another RN writes:

> Dear Anne,
>
> I was furious this am on my unit. Mr. G. (Patient) was abusive and totally unmanageable. Patients were incontinent allover the unit. The place smelled like it never did before. It reaked of urine and feces. No one was assigned to come in early. Patients were climbing out of geri chairs. There was one staff member to do showers, one to make beds, and this left me to do all the rest. You know what that list includes, all the following:meds, treatments, vital signs, policeman duties in the dayroom, mopping, cleaning out the stooped up toilots, and of course preventing falls.
>
> Managemant should not be allowed to get away with this. Do't they care about these patients.
>
> We also had no diapers or gloves, so what else is new.
>
> If the units can't be stocked properly it should be reported to management on Friday. Why is this an evert weekend deal? Every department is passing the buck on this.
>
> With all this you want a Report of Contact? What for? You really don't think it will make a difference? Please get a grip on reality........
>
> Thanks
> M

Demoralized working conditions like poor pay are only two series of crisis' effecting recruitment and retention. There are two other major areas having severe consequences on recruitment and retention. One is the emasculation of benefits and the other applies to rights of employees under the Civil Service Reform Act of 1978.

In regards to the benefits area please consider the following:

1) Operating Room Nurses are denied night, Sunday, and Saturday differential. Management found a loop hole in Congressional action, a loop hole that is used against employees. We of the Union do not believe Congress ment to exclude these employees. We believe this because not all hospitals have applied the same regulation in the same manner.How can one regulation have more than one interpertation and be applied inequitably at different hospitals? As a result these highly specialized employees have become difficult to recruit, and impossible to retain. They will leave once they see how shoddly they will be treated.

2) Saturday differential is provided to RN's due to Congressional action, given to LPN at the Hospital Directors discretion and denied to Nursing Assistants by Congressional silence. LPN's and NA's are vital members of the team. Without them providing care would be impossible These employees work side by side with RN's, and providing Saturday differential would be such a small way of improving working relations and pay of lower grade employees.

3) COLA's have been denied employees on Special Saleries. Congress gave federal employees their COLA's and by what right did the VA have to deny the COLA? This has been challenged by the unions with a win for the unions. The VACO management team told representatives of the VA Council (NFFE) of which I am a Regional VP that the VA will enact backpay from the time of the court decision. They have not yet lived up to this. Additionally, this agreement does not address the entitlement to the 6 years of denied pay. NFFE must now appeal to GAO but why should we have to.Congress gave us our COLA. The VA did not nave the right to take it. The courts agreed. Congress should step in require the backpayment. The VA should not be allowed to treat employees this way.

4) Management at Northport (and other VA's) requested a cross the board Special Salery for RN's because there was a severe impact upon the VA's ability to recruit RN's. Upon approaval management reconstructed RN employment histories, negating above minimum enterance rates, some promotions and special advancements. Of 268 RN's in the bargaining unit at Northport, 141 of them lost 1 to 5 steps. RN's got special saleries and lost COLA's and steps. VA gave with one hand and took double back with the other. Again the Union does not believe that Congress ment to demote and take away from RN's (and others) when giving special saleries.

Taking a husban/wife team working here at Northport: the husban made $3000 more per year than his wife untill after reconstruction. Now he makes $1000 less per year than his wife.

This had a demoralizing effect on employees. Of the 141 who lost steps. 37 have resigned or retired, all within about a year of the reconstruction. The VA can not keep treating professional employees this way. Not if they really want to retain them.

5) Holiday pay for RN's working Compressed workweek schedules requires duel compensation for all hours worked on the holiday. The VA however has denied 2-4 hours of pay/holiday to each RN. The NFFE VA Council has finalized a grievance to be issued to the VACO on this matter. Again the Union must take a strong demonstration against management to obtain compliance with Congression Action. Again I ask you, can the VA really afford to treat professional employees this way? How long can this go on before professional employees get tired of the games and leave?

6) Uniform allowances for employees required to wear uniforms is capped at $125.00/year as provided for by Public Law 89-504 enacted in 1966. The current $125 cap creats undue hardship for federal employees. In recognition of this hardship, Congress has raised the cap to $400 for Park Service, Forest Service and Corps of Engineers employees. NFFEfirmly believes that all federal workers should have parity with the increase in the uniform allowance cap. This such a small thing which would help so much.

7) Management at Northport decided that all nursing personnel will be required to receive training in OREM's self care deficit. Each unit was stripped of all their staff while a floating team covered the unit. This was done for managements comfort regardless of single parents, school, or second jobs. The employees would lose the differentials when removed off irregular tours. NFFE objected and was assured that it's members would get their differentials. The LPN's and NA's (represented by AFGE) were denied their differential because there was no regulation to allow them to get it.

The lower grade employees can not afford denied pay of any form. While NFFE doesnot represent these employees at Northport, the RN's do not feel they were treated fairly.It added to the strain already felt by these employees who have lost while RN's lost nothing. The same RN's who get Saturday differential that the NA's are denied. The VA can not keep treating employees so blatently different and also expect that employees will not give up and leave. This type of demoralization is destructive.

The points that I am trying to make with these examples of benefits and care problems are:

1) There are insuffient numbers of lower grade employees thus requiring professional employees to do tasks at a higher cost factor to the system.

2) Congressional actions regarding pay, differentials and benefits are applied unevenly, unfairly, and discriminatly. This often hurts lower grade and speciality areas (like RN's) the hardest.

3) Pay to lower grade employees is inadequate and insuffient making the recruitment of these employees impossible especially when they can do better elsewhere.

4) Budget cuts have resulted in gutting staff levels in support services to a level where care is in jeopardy. Work expectation of those remaining is unreasonable. Work is often incomplete.

5) Budget cuts have resulted in inadequate and often lacking of supplies and equipment. Inappropriate supplies are used due to the lack of proper supplies such as using sterile gloves instead of unsterile gloves. Sterile gloves cost considerably more than unsterile gloves.

6) It cost you out of pocket to be a federal employee. Uniforms are expensive. Lower grade employees really feel the shortage.

7) The unclean and unwholesomenessof the enviorment adds to the overburdened system and fails to convince employees to remain especially when they can go someplace cleaner to work and earn more.

In essence the VA system is driving employees away, and you can't pay them enough to stay.

This is more than the numbers of beds or patients the system services or cares for. This is a defunct system trying to make ends meet. To quote G. Shaffer Region 5 VA Council VP who reported to the entire Council:

> "The Veterans Administratiin Hospital in Amarillo,Texas has recently expanded its old hospital facility at a cost of $18.5 Million plus in FY88. Now they are in the construction stage of completing a fully modernized 150 bed nursing home care unit at an additional cost of $8 Million by FY 90.
>
> With all this existing facility, one might think that this would be a wonderful place in which to work due to its outside appearance and elegant charm. If this is the case, why is it that already stressed employees are having job descriptions changed by management to accommodate the demanding workload created by short staffing. For several years now, management has been blaming the problems that are being experiencing at this facility on VA budget cuts.
>
> If the VA has money from Congress to build a multi-million dollar facility for the Veterans of this country yet has no money left to hire adequate numbers of qualified personnel to take care of the increasing workload which is created by the expansion, or the money to purchase the necessary parts to repair equipment, or to purchase supplies; then why are we expanding in the first place?
>
> Without adequate, qualified personal in all departments to properly administer to the needs of the American Veteran, a beautiful multi-million dollar hospital with all its fancy equipment serves no additional purpose than a smaller less equiped facility"

The same can be said for Northport. If there is insuffient employees, supplies, and equipment to care for what we presently have, how will we care for the new nursing home due to open June 6, 1989.

A problem at all VA hospitals in regard to negotions for Title 38 employees is in regards to their rights under the Civil Service Reform Act. Recent FLRA positions have been based on the Colorado Nurses Decision. As long as Title 38 employees are denied the same negotion and grievance rights as Title 5 employees recruitment and retention will not improve. American Nursing Associations have well publiczed the decision and no professional employee will tolerate this treatment. Those that can leave....have. Others are expected to leave as the negative effects of this are felt. As a National Vice President, VA Council VP, and Local President I have seen the negative effects it has had on moral, work performance, attitude, recruitment and retention.

We must have the removal of Colorado Nurses if we are to survive. Please don't believe it if management tells you that they have not implemented Colorado Nurses. If Title 38 employees really could negote working conditions things might not be as bad as they are. We would have yelled louder. We would have had more input before it got this bad. We would have negoted over these working conditions.

Thank you for you allowing me this opportunity to speek to you. I wil be available for questions or you may feel free to call me if you wish. (516 261-0835).

(516) 261-4400, Ext. 2315
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LOCAL 1843
American Federation of Government Employees
(AFFILIATED WITH THE AFL-CIO)
V.A. MEDICAL CENTER
NORTHPORT, NEW YORK 11768

Field Hearing: Subcommittee on Hospitals and Health Care
Committee on Veteran's Affairs
DVA Medical Center, Northport, N.Y.
May 15, 1989

Testimony of: Nathaniel Holmone, President
American Federation of Government
Employes Local 1843

AFGE LOCAL 1843 REPRESENTS APPROXIMATELY THIRTEEN HUNDRED (1300) OF THE EMPLOYEES AT THIS MEDICAL CENTER IN BOTH OUR PROFESSIONAL AND NON-PROFESSIONAL BARGAINING UNITS. AS A REPRESENTATIVE OF EMPLOYEES, WE HAVE BEEN DIRECTLY INVOLVED IN ISSUES REGARDING SHORT STAFFING, RETENTION OF EMPLOYEES, PAY INEQUITIES AND RECRUITMENT OF NEW EMPLOYEES. ALL OF THESE FACTORS NEGATIVELY IMPACT UPON OUR EMPLOYEES, WHICH DIRECTLY AFFECTS THOSE WHOM WE ARE HERE TO SERVE, THE VETERAN PATIENT.

THE MEDICAL CENTER HAS BEEN FACING A SERIOUS SHORTAGE OF DOCTORS, NURSES, LICENSED PRACTICAL NURSES,NURSING ASSISTANTS, HOUSEKEEPERS, X-RAY TECHNICIANS AND OTHER POSITIONS. TEMPORARY EMPLOYEES ARE HIRED TO FILL STAFFING SHORTAGES AS A STOP-GAP MEASURE WHICH FAILS DUE TO THESE EMPLOYEES INELIGIBILITY FOR BENEFITS, LOW PAY AND EXPOSURE TO THE SHORT STAFFING. THIS RESULTS IN THEIR QUITTING IF THEY ARE NOT MADE PERMANENT.

DUE TO SHORT STAFFING, EMPLOYEES ARE REQUIRED TO WORK DOUBLE SHIFTS, WORK MANDATORY OVERTIME WITHOUT CONSIDERATION FOR THEIR PRIVATE AND PERSONAL LIVES, HAVING THEIR WORKLOAD INCREASED GREATLY, ALL OF WHICH NEGATIVELY AFFECTS THE VETERAN PATIENT. THERE HAVE BEEN INSTANCES WHERE VETERAN PATIENTS HAVE BEEN TURNED AWAY DUE TO LACK OF NURSES TO CARE FOR THEM, DOCTORS DOING THE WORK OF NURSES, TECHNICIANS SO OVERLOADED WITH WORK THAT THE VETERAN PATIENT SPENDS HOURS WAITING FOR TESTS AND CARE.

OUR OTHER EMPLOYEES WHO SUPPORT THE MEDICAL TEAM AND KEEP THE MEDICAL CENTER OPERATING ALSO SUFFER FROM INCREASED WORKLOAD, UNPLANNED OVERTIME AND INEQUITABLE SALARY. SPECIAL SALARY RATES FOR THESE EMPLOYEES HAVE BEEN PENDING FOR OVER A YEAR, YET, THEIR WORK INCREASES WITH NO RELIEF IN SIGHT. WE HAVE HAD CASES WHERE EMPLOYEES SHIFTS WERE CHANGED TO AVOID PAYING SHIFT DIFFERENTIALS, YET WE SEE NEW CARPETING AND FURNITURE INSTALLED IN THE ADMINISTRATION BUILDING AND OTHER BUILDINGS TO REPLACE FURNITURE AND CARPETING THAT IS LITTLE OVER A YEAR OLD. WHERE IS THE EQUITY AND FAIRNESS FOR THE EMPLOYEE ?

THE FACT THAT WASHINGTON HAS CUT THE VA BUDGET IS IN EFFECT TELLING OUR VETERANS WHO HAVE SERVED THEIR COUNTRY THAT THEY NO LONGER MATTER, WHICH ANYONE OF A REASONABLE MIND WOULD CONSIDER TO BE OUTRAGEOUS. WE HERE AT THIS MEDICAL CENTER NEED THE NECESSARY FUNDING TO CARE FOR OUR DESERVING VETERANS AND EQUITABLE COMPENSATION FOR THOSE INVOLVED IN THEIR CARE. TOWARDS THAT END, AFGE REQUESTS THE SUPPORT OF THIS SUBCOMMITTEE.

PREPARED STATEMENT OF EDWARD GRANKA, VAVS REPRESENTATIVE

Mr. Chairman and Members of the Subcommittee:

The Suffolk County Org. of the American Legion is appreciative of this opportunity to express its concern regarding the inade--quate funding problems at this facility and the medical centers nationwide. We do have a problem her and at the other 171 VA Medical Centers.

The main problem here at the Northport VA is the closing of Building 11. With the transfer of 75 to 80 patients and the entire staff in Bldg. 11 to the new 120-bed Nursing Home, in addition to some patients from Bldg. 9 and Bldg. 200. Also, 100 per cent service --connected Veterans in the private contract Nursing Homes will be asked if they would care to be moved to the new home and how many will opt for this is not known. In reality, it is not a 120-bed gain for Veterans that are in need of nursing care - at the most, the gain is about 30 and not the 120-bed gain we were led to believe from the start. Reason - funding.

Veterans that were placed in private contract Nursing Homes had a maximum stay of six months and a bed space of 120 Veterans. Well, that is not the case again. Maximum stay is three months down from 180 days, and bed space for 80 Veterans, down from 120. Reason - funding.

When a Veteran is placed in a private contract Nursing Home, the VA picks up the 90-day stay --if the Veteran is penniless what happens. There is nothing a Veteran can do in 90 days even with the Social Worker assisting, it takes more than 90 days to get the wheels for Medicaid to start work. To get the Dept. of Veterans Benefits to process claims for Veterans and family in question for benefits if Veteran is eligible is a joke - a waiting period of six to nine months to process a claim is the norm.

Mr. Chairman, when the new Nursing Home was under construction, Central Office and those responsible knew that Bldg. 11 would be closed long before the new home was completed. Plain logic - Bldg. 11 should not be closed. We all know the problem - funding. The Northport VA Medical Center is Two and one half million dollars short for this FY 1989. Central Office knows this - they also know the needs of this facility. I believe Mr. Manley has presented his problems to them but it seems to go unheeded.

I believe when they devised the Means Test for Hospital/Health care for Veterans, putting them in Category A, B and C, that this was a law , PL 99-272, such is not the case again. Most VA Medical Centers are not honoring this law - 80 per cent by our recent survey. We would like to know what good is PL 99-272 if all Directors at the 172 Medical Centers did this. Reason is funding. The reason this Medical Center is honoring B and C Veterans is the price we pay to close Bldg. 11 - lack of funds.

In Bldg. 200 there is a surgical unit closed. I questioned the closing and did receive an answer. By closing this Unit they still had an occupancy rate of 86%. I wonder tho' if, in the following weeks, there was aneed for Veterans to be admitted in this Unit, would it remain closed. Nationwide we have 13,000 beds looking for Veterans. I wonder if additional funding were available, could these empty beds be utilized for some type of nursing care etc. or relax the rules for eligibility.

Over the years, I have seen many benefits and programs eliminated. To name a few- last year a Veteran rated 30% service-connected was eligible for extra benefits - that has changed - it is now 50% or over. It scares me to think that when they start trimming the budget for the VA it will be 60, 70, 80 per cent and before long it would be 100% service connected only. The beneficiary travel pay is another item - it has been partially restored with a Six Dollar deductible and Eighteen Dollar cap. We belive that if a service-connected Veteran came for that particular ailment, he sould be fully reimbursed. It also hurts some Veterans financially.
A Veteran as an outpatient and on medication is given a refill slip with a self-addressed envelope, stamped with the US Postal logo, no more, it is as if this program cost in man hours. It cost the same with or without the free postage. Another way to get the Veteran to pay.

In ten years the percentage of total Federal benefits and service was 4.4 %- since there has been a decrease, down to 2.6%. Can it get lower. The past ten years the amount allocated for Veterans has increased from Twenty Billion Dollars, which equates to a mere 45% increase. While all federal spending during the same period has risen from 491 billion dollars to 1.1 trillion, a 124% increase. The fastest growing area of the VA budget is health care, and that has been tightly controlled. Ten years ago, the heaLTH CARE System operated on an annual cost of $5. 2 billion and the Veterans Health Care System costs this year are $10.6 billion, which rrepresents a 104% increase. Now, over the same period of time, Medicare spending jumped from $26 billion to $87 billion, an increase of 235 per cent. In comparison, the Veterans Programs has been a model of fiscal restraint. The Department of Veterans Affairs Medical Care System increased its inpatient and outpatient treatment since 1979 from 18 million to 24 million visits per year and in each of those years they have cut the VA Budget. I would say the VA system was very efficient, workers very loyal, but how much can they lower funding for Veterans Programs and lowering the work force in the system.

Help is needed badly in the ETA Area, it seems there is a doctor shortage in that area.

I also find that medical appointments are rescheduled and they are spaced further apart, and, at that rate, they can cut your visits from three months to six or more. Whether this is another cost saving program, I do not know. I do see large waiting lines where we turn the folders in and, as a rule, there is but one secretary to handle the phone, handle the folders and to make the clinical appointments, etc.

Civil Service Commission, two years ago, approved and recommended an across-the-board raise of 25% but VA Personnel at Northport Medical Center never received such. It was then passed to the IRS where it is still awaiting approval. This clerical raise then has to go to the Treasury Department and its final destination - OPM.

I believe that, if the increase in salary is not forthcoming, you may lose some key clerical support. Compensation in certain areas for job performance is not adequate. Clerical help is a hub of the VA.

Edward Grenka
VAVS Representative

Service Officer, Suffolk Cty.

PREPARED STATEMENT OF MRS. YOLANDA ADKINS

I guess that I am supposed to say that it is a pleasure to be here, but under the circumstances, it really isn't. However, I am glad to have the opportunity to address this audience. You are aware of the problems facing veterans today all across the country. What is the answer? Money!!!

I served overseas in Africa and the invasion of Italy. I saw how some of our men were brought into the hospitals, some so unrecognizably mangled, begging to be killed because they couldn't stand the pain. I am outraged when I think about them being denied medical care they were promised. We know there is a lack of adequate funds to provide satisfactory health care for veterans. Millions of dollars are sent all over the world, even though we know that much is wasted, and some going into the hands of corrupt public officials. But there is never an extra dollar for veterans.

When we went off to war, the majority of us as volunteers, we made a commitment, and we kept that commitment. Our government made us a commitment also, which over the years, they have been trying to abolish.

We are not against elected officials getting a reasonable pay raise. But should they not "bite the bullet", the way they keep telling us to do? If they spent less time on speaking appointments and more time on the budget, I'm sure they could come up with an equitable solution to this crisis. We are told that we must pay higher salaries if we want to attract the more capable people for public office. I agree with that. But doesn't that apply to the veteran's hospitals as well? It is getting more difficult to recruit and retain physicians and nurses for our VA Hospitals because of the low pay scale. When a physician leaves us, it is usually because they can earn much more money in private practice.

We have the most sophisticated machines in this hospital, but they aren't doing us any good, because we don't have the technicians and qualified people to run them. If a machine becomes in operable, it could take days or weeks before it is repaired, because there is no money allowed for such emergencies at that time.

There are all kinds of problems all over the hospital, and ETA is no exception. The worst problem is being short staffed, therefore creating many long hours of waiting for many patients. When a doctor goes on vacation, or is out sick, there is no coverage. Right now our Dr. in ETA, is diligently trying to update and make the ETA more efficient. No matter what recommendations or suggestions she offers, she is told she can't implement them, because there is no money for such programs. She has recently put into effect, the triage program, which means that patients with life threatening problems, are seen first. That is great for those particular patients, however the other patients can wait for hours. The ETA not only serves the outpatients, but also about ten other outlying units when emergencies arise. Triage requires additional staff, but they have not been allowed any. If you get stuck after 4 PM, you may as well go home. And God forbid if you should get sick on a weekend, there is only one doctor to take care of the ETA and whatever happens on the units. And if the ETA staff has to answer emergencies within the hospital, what happens if a critical patient is brought into ETA at the same time? So take advice from one who knows, don't get sick on a weekend.

It has only been in recent years that women veterans have received any consideration in the VA System, and the little that was given, was given reluctantly. Now that women veterans have finally been able to take advantage of the health care system, it is being jeopardized by unmerciful financial cuts from our government. On one side, medical centers are told to outreach to women veterans, but funds are not provided for the women they attract. First, we had to put up with the resentment and attitudes of the doctors, then refusal to stock medications for us in the pharmacy.

With the formation of the Women Veteran's Advisory Committee, which I co-chair, we have been able to see the light at the end of the tunnel, so to speak. We were able to make known our needs. The response has been surprising. While there is no provision made for mammagrams in the hospital, and there still is no gynecologist at the medical center, these services are contracted out, and we can get most of the medications we need. There also have been other changes for the better. Another plus for the women veterans is the Women's Health Clinic. The amount of women using the VA Hospital has increased greatly, with over 2,550 in data base, and over 450 admitted since August 1985. Just since last October there have been over 700 women patients on active rolls. Many do not come because of the lack of a certified gynecologist, and I know there would be many more if we had one. Even though women have been turned off in the past, I hope to see even more of an increase using the VA System, now that we are finally getting recognition.

There is one other area that I would like to mention before closing, and that is the record room. That is my baby, because that is where I do most of my volunteering. Those people are overworked, understaffed and underpaid, to say the least. Because of the tremendous amount of records kept there, we must use more than one room, which makes the situation more difficult, because you have to run back and forth, so a great deal of time is wasted. Records can't be kept in order because of the lack of room, plus the shortage of personnel. I have seen reports from last year that haven't been put in the patient's folder as recently as the last few weeks. Reports get lost or misfiled because there just isn't anyplace else to put them. We were told last year, that the whole area was going to be changed and everything would be in one large room. There would be a place for everything and everything would have a place. Yes, there were changes made; Several pieces of furniture have been moved around. But there is simply not enough room to make the necessary improvements.

We cannot allow our health care programs to be destroyed. This time our government must listen to us, and we must demand that they restore money they have taken away from us. Without it, we cannot hope to attract physicians, nurses and other vital clinical and clerical personnel, necessary to operate our hospitals successfully and efficiently, and in order to accomplish this, we will not give up.

PREPARED STATEMENT OF FELICIA PASCULLI UDELL

Good Morning and welcome to Long Island on behalf of the patients and families of patients at the VA Medical Center in Northport. My name is Felicia Pasculli Udell; I live at 41 Eaton Lane, West Islip, New York. I am married, have three children, own a business, am a Vice-Chairman of the Long Island Alzheimer's Foundation, and am a member of Concerned Families of Patients at the Northport VA Hospital. I am giving you this background not to impress you with my versatility, but rather to point out to you that I am a responsible, hardworking, caring member of my community, who resents the fact that I have had hours upon hours taken away from caring for my family, business and father because I've had to fight for what he and others like him can no longer fight for - their rights as veterans of this country.

The more families I speak to, the more I realize that this is a common predicament among families concerned with this VA Medical Center. The sword of Damocles is hanging over everyone's head. Rather than find solutions we come up with painful questions. Why is the budget being cut at a time when we have an aging veterans population that are hopefully, representatives of the last global confrontation we'll suffer. Why especially at Northport, a center serving an area of the nation with the highest density of World War II and Vietnam veterans? Why is the Medical Center choosing to cut the services of the oldest and the weakest? Is this the same government that set the example for civil rights and rights of the disabled? What message is being sent regarding treatment of the elderly? The veterans population reflects the population at large. Does increased longevity mean living long enough to see promises broken?

A case history from the Medical Center follows.

Exhibiting behavior common among victims who blame themselves for the crime, many veterans groups blame themselves and other veterans for not fighting the cuts that have taken place over the last several years. Why should they feel this way? Why should a person who served his or her country honorably, sometimes under the most horrendous conditions, have to fight for what was promised? Who would have imagined a time when the government breaks its own laws regarding those promises? When a government legally mandated to provide approximately 90,000 beds nationwide, provides money for 55,000? What was the purpose of conferring Cabinet status to Veterans Affairs? Was it to provide a diversion for the ambush?

Let me tell you about my father, Patsy Pasculli. My father is a disabled World War II veteran suffering from Alzheimer's Disease and a host of other ailments. He is in Building 11 at this Medical Center. Any time my father sought medical treatment or consultation during my lifetime, it was at a VA Medical Center. I truly believe he felt better understood and better cared for at the VA facilities. He came to this facility as an acute care patient and was eventually transferred to an Intermediate Care Unit, which is a euphemism, since there have been patients in those units who have stayed as long as 40 years. In between his acute care stay and his present stay, he was transferred to a contract nursing home, where he almost died. He developed pneumonia and blood poisoning. Fortunately, he recovered and was transferred back here. In addition to the care extended to the patients by the nurses and aides here, I believe the patients feel a dignity and self-esteem lacking in many other facilities.

Apparently, the Administration of this Center does not understand this perspective. Why are they so belligerent toward patients and their families?
Two case histories follow.

Why, at a time when the hospital's own statistics prove the need for chronic care beds and the underutilization of acute care and rehabilitation units, has the focus of the new nursing home been changed to geriatric rehabilitation and clinically complex cases? Why has the focus of the home been changed from long-term care to 90-day stays, when at the same time the hospital has cut the time it will pay in a contract nursing home from six months to three months? Are they determined to pauperize as many families as possible? Getting back to the new nussing home - Who made the decision to change the nature of the nursing home, and how could this policy change been made in light of veterans needs on Long Island? How could it have been made in light of Secretary Derwinski's comments recently: In response to a question on saving money for health care purposes by closing down under-utilized VA hospitals, (nevermind one in an area as densely populated with veterans as ours) Derwinski said the following: "It won't be the issue of closing. I don't believe we'll have to close any facility. What we may do is readjust their mission, from a total hospital entity, perhaps to more long term health care, more of a veterans, senior veterans housing entity rather than a full-blown hospital."

What are the criteria for admission into the nursing home, into the intermediate care units, into the hospice? Why has the Administration consistently failed to answer these questions? Are there federal guidelines to be followed? Are they being followed? The Administration has talked of getting higher reimbursement for certain patients as opposed to others. Is this so? If it is so, then how does the reimbursement work? Is it a money system, is it a points system? Does the VA ever get any reimbursement from private insurance companies or governmental agencies? If not, why not?

The budget cuts must be restored. They have resulted in hardships above and beyond those perpetrated by the Administration. Patients never have enough socks, pajamas, linens, working wheelchairs. There have been horror stories of shortages occuring during surgery and lack of vital medication. This county, which has the most vietnam veterans in the country, desperately needs a post-traumatic stress disorder clinic. You must restore the cuts, you have a moral obligation to do so. Or, perhaps one day you'll give a war and no one will come.

I have asked you many questions on behalf of many families and patients at this center. Hopefully, you received some insight into the frustrating dilemmas we've experienced. We would like to know how much time will pass before these questions are answered truthfully and definitively. Once again, thank you for coming to Northport!

PREPARED STATEMENT OF SUFFOLK COUNTY CHAPTER 11, VIETNAM VETERANS OF AMERICA

MR. CHAIRMAN AND MEMBERS OF THE HOSPITAL AND HEALTH CARE SUB COMMITTEE.

THE SUFFOLK COUNTY CHAPTER OF VIETNAM VETERANS OF AMERICA INC. (VVA) APPRECIATES THIS OPPORTUNITY TO PRESENT IT'S VIEWS ON THE NEEDS AND PROBLEMS AT THE DEPARTMENT OF VETERANS AFFAIRS HOSPITAL AT NORTHPORT. IN THIS STATEMENT WE WILL BE ADDRESSING THE NEED FOR A PTSD STRESS UNIT. THE PROBLEMS THAT THIS HOSPITAL IS EXPERIENCING WITH THE RECRUITMENT AND RETENTION OF STAFF, AND A NUMBER OF OTHER ISSUES THAT ARE OF CONCERN TO ALL VETERANS IN THE HOSPITAL'S CATCHMENT AREA.

WE WOULD LIKE THE COMMITTEE TO KNOW THAT PRIOR TO COMPILING THIS REPORT. AND TAKING OUR POSITION ON THESE ISSUES, SELECTED MEMBERS OF OUR ORGANIZATION MET WITH MANY OF THE DEPARTMENT HEADS WITHIN DVA NORTHPORT. IN ADDITION. SOME OF OUR MEMBERSHIP ARE VOLUNTEERS WITHIN THE HOSPITAL AND AT THE LONG ISLAND VET CENTER WHILE OTHERS ARE PATIENTS AND EMPLOYEES. ACCORDINGLY. WE BELIEVE THAT WE ARE QUALIFIED TO ADDRESS THE SPECIFIC PROBLEM AREAS OF DVA NORTHPORT.

THE NORTHPORT HOSPITAL SERVES ONE OF THE LARGEST VIETNAM ERA POPULATIONS IN NEW YORK STATE, IF NOT THE COUNTRY. BETWEEN NASSAU AND SUFFOLK COUNTIES. THERE IS A COMBINED POPULATION OF 78,670 VIETNAM ERA VETERANS WHOSE READJUSTMENT NEEDS ARE ADDRESSED ONLY BY A FIVE MEMBER TEAM AT THE LONG ISLAND VET CENTER. THIS TEAM IS COMPOSED OF THREE READJUSTMENT COUNSELORS. ONE TEAM LEADER. AND ONE OFFICE MANAGER. ALTHOUGH PERFORMING IN A MOST COMMENDABLE AND PROFESSIONAL MANNER. IS WOEFULLY INADEQUATE IN TERMS OF TEAM SIZE TO DEAL WITH THE PRESSING NEEDS OF VETERANS SUFFERING FROM POST TRAUMATIC STRESS DISORDER. (PLEASE SEE ATTACHMENTS A AND B)

ACCORDING TO THE TRIANGLE INSTITUTE STUDY DONE UNDER CONTRACT TO THE THEN VETERANS ADMINISTRATION, 15 PERCENT, OR 470,000 OF THE APPROXIMATELY 3 MILLION MEN AND WOMEN WHO SERVED IN VIETNAM ARE CURRENTLY SUFFERING FROM MANIFESTATIONS OF POST TRAUMATIC STRESS DISORDER. IN ADDITION, IT HAS BEEN REPORTED THAT THE VETERANS ADMINISTRATION HAD FOUND THAT ONE IN EIGHT WORLD WAR II COMBAT VETERANS AND ONE IN TEN KOREAN WAR VETERANS CURRENTLY USING DVA MENTAL HEALTH OUTPATIENT PROGRAMS ARE ALSO SUFFERING FROM THE EFFECTS OF POST TRAUMATIC STRESS DISORDER. ALL CURRENT STUDIES ARE VERIFYING AN ABSOLUTE NEED FOR CONCRETE PROGRAMS AND SERVICES DIRECTED SPECIFICALLY AT THE TREATMENT AND CARE OF VETERANS AFFLICTED WITH PTSD. (PLEASE SEE ATTACHMENTS C AND D)

TO DATE. IN OUR REGION. THE CLOSEST FACILITY ADDRESSING THESE NEEDS IS THE D HOSPITAL AT MONTROSE. N.Y. THIS FACILITY'S CATCHMENT IS THE ENTIRE DOWNSTATE REGION AND IS LOCATED OVER 100 MILES FROM DVA NORTHPORT. IT IS NOT DIFFICULT TO UNDERSTAND THAT ONLY ONE FACILITY WITH A 13 BED UNIT. ATTEMPTING AS THEY MIGHT TO DEAL WITH THE EXPANDING NUMBERS OF VETERANS REQUIRING TREATMENT FOR PTSD. CANNOT DEAL WITH THE NEEDS THAT EXIST. IN FACT. A 1987 GOVERNMENT ACCOUNTING OFFICE REPORT. "VIETNAM VETERANS A PROFILE OF VA'S READJUSTMENT COUNSELING PROGRAM" INDICATES THAT FULLY 75 PERCENT OF THOSE REFERRED BY VET CENTERS TO EXISTING IN-PATIENT PTSD PROGRAMS WERE TURNED AWAY DUE TO THE INADEQUACY OF THESE PROGRAMS. THIS SHORTFALL IN DVA SERVICES REPRESENTS A CLEAR AFFRONT TO THOSE VETERANS SO DESPERATELY REQUIRING TREATMENT ALONG THESE LINES.

THE DATA CITED ABOVE CLEARLY DEMONSTRATES THAT WHAT SERVICES CURRENTLY EXIST TO TREAT PTSD IN OUR REGION. AS WELL AS THE NATION, ARE DEPLORABLY INADEQUATE.

AS SUCH, VVA BELIEVES THAT THE ONLY SOLUTIONS TO ADDRESSING PTSD TREATMENT SHORTFALLS ARE, (1) THE ESTABLISHMENT OF AN INPATIENT PTSD TREATMENT UNIT AT DVA NORTHPORT, (2) INCREASED STAFFING AND FUNDING LEVELS AT THE LONG ISLAND VET CENTER IN BABYLON, N.Y., AND (3) THE CREATION OF A MANDATORY PTSD SENSITIVITY TRAINING PROGRAM FOR ALL DVA NORTHPORT EMPLOYEES. (PLEASE SEE ATTACHMENT E)

WE WOULD LIKE AT THIS TIME TO BRIEFLY ADDRESS AN ISSUE THAT IS RELATED TO THE PROBLEMS ASSOCIATED WITH BOTH PTSD AND THE RISING COST OF LIVING ON LONG ISLAND. HOMELESSNESS. DURING 1988 DVA NORTHPORT SERVICED 685 HOMELESS VETERANS THROUGH THEIR SOCIAL WORK SERVICES. IN JANUARY 1989 ALONE, 77 VETERANS HAVE ALREADY RECEIVED SOME SERVICES FROM THIS FACILITY.

VVA SUPPORTS DVA NORTHPORT'S PROPOSAL FOR THE ESTABLISHMENT OF A DOMICILIARY CARE FOR HOMELESS VETERANS PROGRAM WITH THE FUNDING REQUESTED. (PLEASE SEE ATTACHMENT F)

WE WOULD NOW LIKE TO ADDRESS THE ISSUES OF RECRUITMENT AND RETENTION OF HEALTH CARE PROFESSIONALS AS WELL AS SUPPORT AND CLERICAL PERSONNEL AT DVA NORTHPORT.

THE PROBLEMS, AS WE SEE THEM, ARE THREEFOLD: (1) CURRENTLY HEALTH CARE PROFESSIONALS ARE BEING FORCED TO PERFORM OUT OF DISCIPLINE TASKS DUE TO THE SHORTAGES OF VARIOUS SUPPORT STAFF POSITIONS. THIS SITUATION TRANSLATES DIRECTLY INTO A REDUCTION IN THE QUALITY AND QUANTITY OF HEALTH CARE SERVICES PROVIDED TO AMERICA'S VETERANS. (2) SALARY LEVELS THROUGHOUT THE HEALTH CARE SYSTEM AT THIS FACILITY ARE CONSIDERABLY LOWER THAN THOSE AT OTHER DVA HOSPITALS IN OUR REGION, i.e. BROOKLYN, BRONX, MANHATTAN, ETC. AND THE PRIVATE [illegible] THIS CREATES AN UNHEALTHY ATMOSPHERE WHEREIN RECRUITMENT AND RETENTION OF PERSONNEL WITH NEEDED SKILLS IS VIRTUALLY IMPOSSIBLE, AND (3) THE LACK OF AN AGGRESSIVE RECRUITMENT AND HIRING POLICY BY PERSONNEL ADMINISTRATORS AT DVA NORTHPORT HAS EXACERBATED THE STAFFING SHORTFALLS OBSERVED AT THIS FACILITY.

AFTER SPEAKING WITH DVA NORTHPORT SERVICE CHIEFS AND RESPONDING TO OUR PERSONAL OBSERVATIONS AND EXPERIENCE IT IS THE OPINION OF VVA THAT HEALTH CARE PROFESSIONALS ARE BEING NEEDLESSLY DIVERTED FROM THEIR PRIMARY MISSIONS IN ORDER TO PERFORM FUNCTIONS OF LESSER IMPORTANCE THAN THOSE REQUIRED BY THEIR PRIMARY DUTIES (E.G. NURSES PERFORMING SECRETARIAL/HOUSEKEEPING DUTIES, DOCTORS PERFORMING PARAMEDICAL TASKS, ETC.). COUPLING THIS WITH THE LACK OF DVA NORTHPORT VS. PRIVATE SECTOR SALARY PARITY, IT IS EASY TO UNDERSTAND HOW DIFFICULT IT IS TO RETAIN HEALTH CARE PROFESSIONALS IN THIS UNATTRACTIVE AND BURDENSOME ENVIRONMENT. (PLEASE SEE ATTACHMENT G)

IT IS VVA'S ASSESSMENT THAT THIS OVERBURDENING OF PROFESSIONAL STAFF COULD BE ALLEVIATED THROUGH THE IMMEDIATE GRANTING OF A SPECIAL SALARY RATE FOR GS GRADES 01 THROUGH 06. THIS WOULD IMPROVE BOTH RECRUITMENT AND RETENTION OF EMPLOYEES IN THE AFOREMENTIONED GRADE LEVELS THEREBY IMPROVING THE GENERAL ENVIRONMENT FOR BOTH VETERAN PATIENTS AND [illegible] TASKED WITH PROVIDING HEALTH CARE SERVICES. (PLEASE SEE ATTACHMENT H)

FOR MANY YEARS WE HAVE HEARD OF THE HIDDEN JOB MARKET AND HOW MOST JOBS COME THROUGH PEOPLE WE KNOW. MAJOR UNIVERSITIES HAVE DONE EXTENSIVE STUDIES IN THIS FIELD AND HAVE FOUND THAT 85 PERCENT OF ALL JOBS COME FROM PEOPLE WE KNOW, 10 PERCENT THROUGH AGENCIES, AND 5 PERCENT THROUGH NEWS PAPERS. (PLEASE SEE ATTACHMENT I)

DVA NORTHPORT IS SHORT NUMEROUS POSITIONS IN SPECIALTIES THROUGHOUT THE FACILITY. AGAIN, THROUGH DISCUSSIONS WITH SERVICE CHIEFS, IT IS CLEAR THAT THE LACK OF AN AGGRESSIVE RECRUITMENT POLICY AND THE UNUSUALLY LOW CLASSIFICATION OF POSITIONS IN COMPARISON TO OTHER DVA FACILITIES IN THE REGION DIRECTLY IMPACTS ON HEALTH CARE AT THIS FACILITY.

THEREFORE IT THE POSITION OF VVA THAT A COMPREHENSIVE REVIEW OF THE POSITION CLASSIFICATION STRUCTURE BE UNDERTAKEN AND CORRECTIVE MEASURES BE IMPLEMENTED WHERE APPROPRIATE. WE FURTHER RECOMMEND THAT THE PERSONNEL OFFICE ESTABLISH AND MAINTAIN A SOLID WORKING RELATIONSHIP WITH BOTH NEW YORK STATE DEPARTMENT OF LABOR VETERANS PROGRAM MANAGEMENT AND SUFFOLK COUNTY DEPARTMENT OF LABOR. IT MAY ALSO BE TO DVA NORTHPORTS ADVANTAGE TO SEND VACANCY ANNOUNCEMENTS TO ALL VETERANS ORGANIZATIONS IN THE NASSAU SUFFOLK AREA. THE BENEFIT DERIVED WOULD BE A MORE EFFECTIVE AND WIDE RANGING RECRUITMENT PROGRAM FOR DVA ORT.

HAVING COVERED OUR MAIN TOPICS. WE WOULD NOW BRIEFLY LIKE TO TOUCH ON TWO OTHER AREAS THAT ALSO SIGNIFICANTLY IMPACT ON DVA NORTHPORTS MISSION OF QUALITY HEALTH CARE TO AMERICA'S VETERANS.

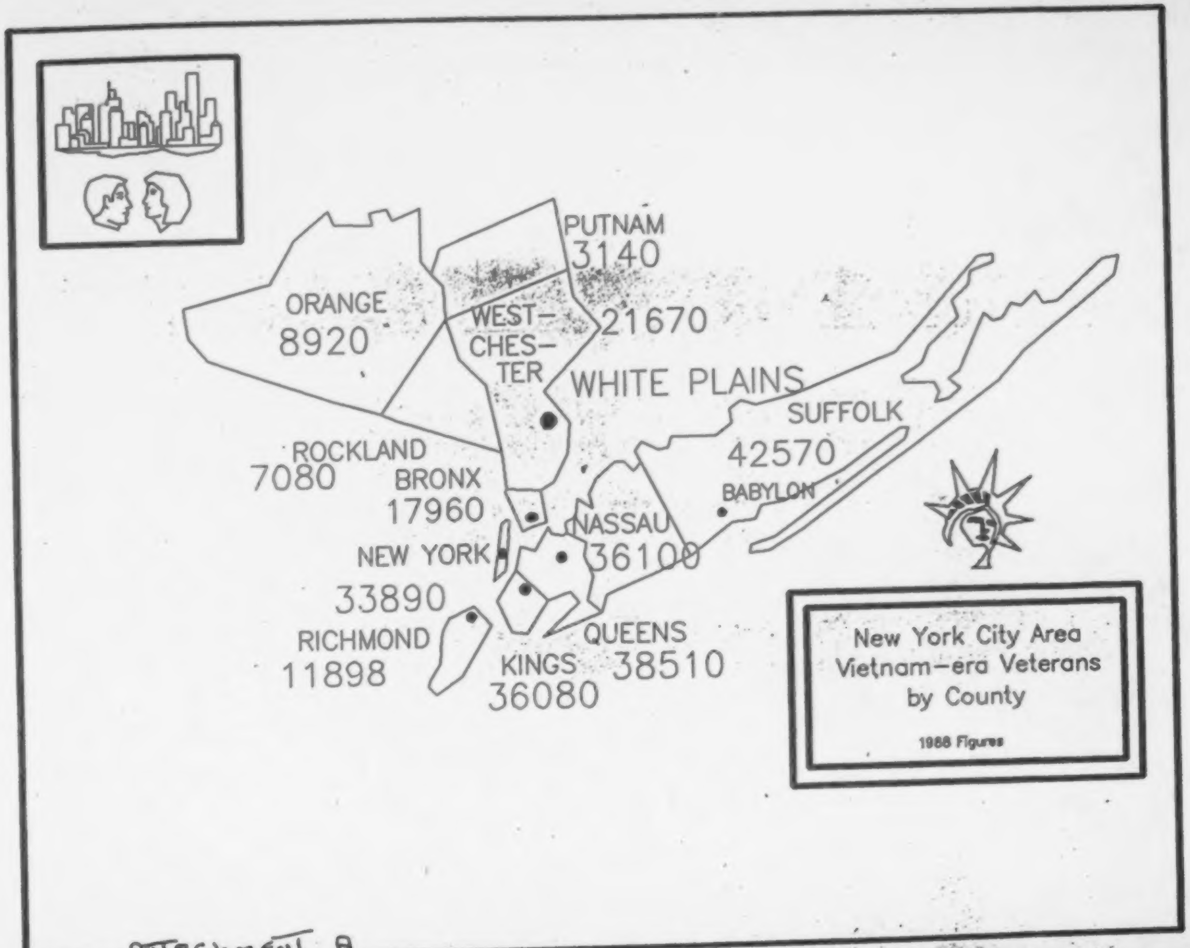
THE PHARMACY SERVICE IS CURRENTLY WORKING WITH A BUDGET 0.56% ABOVE ITS 1988 FISCAL YEAR BUDGET. ACCORDING TO THE CHIEF OF PHARMACY SERVICE AND OTHER PRIVATE PHARMACISTS WE CONTACTED, ALL STATED COSTS FOR MEDICATIONS HAVE RISEN AT A RATE OF 8 PERCENT A YEAR. NEW PHARMACEUTICAL BREAKTHROUGHS BEING RELEASED EACH YEAR AND THE RECENT IMPACT OF AIDS PATIENTS AT DVA NORTHPORT WILL PUSH THE DEMAND FOR MEDICATIONS WELL ABOVE THE 0.56% INCREASE THE PHARMACY BUDGET HAS BEEN GIVEN. (PLEASE SEE ATTACHMENT J)

IT IS THE RECOMMENDATION OF VVA THAT A REALISTIC INCREASE IN FUNDING FOR PHARMACY SERVICES BE GRANTED IN ORDER THAT THIS IMPORTANT PART OF HEALTH CARE SERVICE BE ALLOWED TO CONTINUE IN AN APPROPRIATE MANNER.

IN CONCLUSION, VVA STRONGLY BELIEVES THAT EVERY SERVICE AT DVA NORTHPORT SUPPORTS THE MAIN MISSION OF PROVIDING QUALITY HEALTH CARE TO THE VETERANS OF LONG ISLAND. WE ALSO BELIEVE THAT WHEN ONE SERVICE FALLS SHORT OF PERFORMING ITS FUNCTION, IN RELATIONSHIP TO THE WHOLE FACILITY, THAT THE HEALTH CARE PROVIDED TO VETERANS AT THIS FACILITY WILL SUFFER.

WHEN THE QUALITY OF HEALTH CARE SUFFERS AT THIS FACILITY MANY VETERANS SIMPLY WALK AWAY AND SEEK SERVICES OF OTHER HEALTH CARE PROVIDERS. WHEN THE NUMBERS OF VETERANS SEEKING SERVICES GOES DOWN SO DOES THE BUDGET. THIS AGAIN LEADS TO A DECREASE IN QUALITY SERVICES OFFERED TO VETERANS. THEREFORE IT IS THE OPINION OF VVA THAT CONGRESS MUST ADDRESS THE SHORTFALL IN THE DVA BUDGET AND IMMEDIATELY PASS A SUPPLEMENTAL APPROPRIATION TO ADDRESS THE SPECIAL NEEDS OF THIS FACILITY.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, VVA WOULD ONCE AGAIN LIKE TO EXPRESS OUR SINCERE THANKS FOR THIS OPPORTUNITY TO EXPRESS OUR VIEWS AND CONCERNS ON THESE MATTERS.



New York City Area
Vietnam–era Veterans
by County

1988 Figures

PUTNAM
3140
WEST-
CHES-
TER
21670
WHITE PLAINS
ORANGE
8920
ROCKLAND
7080
BRONX
17960
NEW YORK
33890
RICHMOND
11898
KINGS
36080
QUEENS
38510
NASSAU
36100
SUFFOLK
42570
BABYLON

Attachment B

GAO

Report to the Ranking Minority Member,
Committee on Veterans' Affairs, U.S.
Senate

Attachment B

August 1987

VIETNAM VETERANS

A Profile of VA's Readjustment Counseling Program

GAO/HRD-87-63

Collaboration Between Vet Centers and PTSD Units Needs Strengthening

According to VA, many Vietnam veterans have PTSD, a syndrome created by severely stressful or traumatic events, such as military combat, seeing people die, or incarceration as a prisoner of war. Its symptoms include intense reliving of the event, anxiety, sleep disturbance, depression, social isolation, and an incapacity for intimate relations with others. The Veterans' Health Care Act of 1984 (Public Law 98-528, Oct. 19, 1984) authorized VA to designate special programs for the diagnosis and treatment of PTSD and required that when appropriate, the services provided under this program be coordinated with services provided by the Readjustment Counseling Program. As of November 1986, VA had designated special PTSD units at 13 of its medical centers.[1]

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[1] In addition to the 13 designated units, at least seven medical centers had set aside a defined physical space for treating PTSD patients.

Vet Center Clients Needing Inpatient PTSD Care Frequently Not Referred to PTSD Units

The responses to our questionnaire indicated that, in fiscal year 1985, vet centers that opened before October 1, 1984, together identified over 4,600 clients needing inpatient PTSD care; in fact, 99 percent of those centers identified clients in need of inpatient PTSD treatment. Eighty-eight percent referred a client to a PTSD unit. The centers, however, referred only one-quarter of their clients needing inpatient PTSD treatment to a PTSD unit. Eighty-one percent of the centers said that they treated some clients who needed inpatient care; 71 percent said that they referred some of these clients to support facilities for treatment

The vet centers did not make more referrals primarily because of (1) lack of available beds, (2) distance, and (3) client needs and preferences.

- Lack of available beds: Three of the 12 support facilities visited (the Bay Pines, Northampton, and Palo Alto Medical Centers) had designated PTSD units. The Bay Pines unit, with 20 beds, and the Northampton unit, with 30 beds, were full, officials told us, and additional veterans were waiting to be admitted. According to the Bay Pines official, the average waiting period was 6 months. The director of the PTSD unit at Palo Alto, which had 90 beds, told us that 84 beds were filled. He said this was the normal occupancy, and veterans were rarely put on a waiting list unless it was their choice not to be immediately admitted. Officials at 8 of the 12 centers visited noted the unavailability of bed space as a reason for not making more referrals to the PTSD units.
- Distance: About three-quarters of all vet centers were 100 or more miles from the closest PTSD unit; about one-quarter were 450 or more miles away. At over half the centers (five of eight) we visited that were 100 or more miles from a PTSD unit, team leaders told us distance was a reason that they did not make more referrals.
- Client needs and preferences: At three centers we visited, team leaders told us they would not first refer a client to a PTSD unit if the client had an immediate need for hospitalization or required treatment for other problems. A veteran must be free from substance abuse and acute psychiatric illnesses, officials from two PTSD units told us, to be considered for admission. Moreover, clients may not want to be admitted to a PTSD unit, team leaders from four centers told us, because they do not want to be away from their families or jobs for an extended period of time. According to VA, most PTSD units plan for their patients to stay for from 3 to 5 months.

Limited Contact Existed Between Vet Centers and Designated PTSD Units

VA's Special Committee on PTSD, established by Public Law 98-528 to assess the agency's ability to treat veterans with the disorder, noted that continuity of care between vet centers and PTSD units may facilitate the treatment of those veterans and minimize their relapse. The committee also noted that coordination permitted the efficient use of resources at both locations. As of February 1987, VA did not have guidelines specifying how PTSD units and vet centers should coordinate their diagnosis and treatment of veterans with PTSD.

Vet centers that referred clients to PTSD units in fiscal year 1985, according to responses to our questionnaire, almost always notified the units of the referral by letter or telephone. After the referral, however, most of the centers had little contact with the unit, as shown in table 7.1.

Table 7.1: Contact Between Vet Centers and PTSD Units[a]

	Percent of centers that had contact:			
Type of contact	**Always/ almost always**	**Sometimes**	**Rarely/ never**	**Not applicable**
Telephone/letter notification of referral	92	5	2	1
Meeting/contact verifying diagnosis	41	16	35	7
Meeting/contact developing treatment plan for admitted veteran	16	18	55	11
Meeting/contact developing alternate plan in lieu of admission or while waiting for admission	25	20	45	10
Periodic meetings/ contacts discussing progress	26	23	38	13
Notification of patient discharge	26	20	41	13
Meeting/contact establishing follow-up treatment plan	27	20	41	12
Meeting/contact discussing progress in follow-up treatment plan	12	23	50	16

[a] For vet centers that opened before October 1, 1984

The questionnaire responses did not clearly indicate that distance between vet centers and the PTSD units was a factor in coordination. The majority of centers visited that referred clients to PTSD units in fiscal year 1985 did not fully communicate with the units, for example:

- The Knoxville Vet Center center referred four clients to PTSD units in fiscal year 1985, the team leader there said; he did not, however, know if two of them had been admitted because the units in the Bay Pines and Cleveland Medical Centers did not provide him feedback.
- According to vet center and PTSD unit officials, staff from only one of the four centers we visited that were within 40 miles of a PTSD unit participated in the unit's inpatient treatment program. A St. Petersburg Vet

Center counselor told us that center staff conducted group sessions at the nearby PTSD unit in the Bay Pines Medical Center.

- The Pawtucket Vet Center team leader told us his staff seldom contacted clients in the program who were referred to the PTSD unit in the Northampton Medical Center; the vet center staff did not communicate at all with the PTSD unit staff during the clients' stay. According to the team leader, this was because the PTSD unit staff assumed full responsibility for the treatment of the veterans.
- The Albuquerque Vet Center team leader told us that although the center had eight clients admitted to the PTSD unit in the Topeka Medical Center in fiscal year 1985, staff from the two facilities did not discuss clients' treatment options following hospitalization. He said the vet center independently developed its own posthospitalization treatment plans.

Conclusions

Most vet centers and support facilities collaborated in some way on administrative, clinical, and training matters. Clinical and training collaboration, however, was affected by the distance between the vet center and its support facility. Because some vet centers are closer to satellite outpatient clinics than to their designated support facility, we believe VA should consider linking more vet centers to these clinics, if the clinics can provide the support needed by the centers.

In addition to the law requiring, when appropriate, that PTSD and vet center services be coordinated, the Special Committee on PTSD has indicated that close contact between the vet centers and specialized PTSD inpatient units could improve the effectiveness of the treatment provided the veterans. Although VA may not be able to overcome many of the reasons limiting referrals from vet centers to inpatient PTSD units, we believe it can improve the coordination between the units once referrals are made. Better communication could be accomplished through telephone and written correspondence if distance precludes face-to-face contact. This communication would help assure veterans received coordinated care before, during, and after their stays at PTSD units; if they were not admitted to the units, this communication would help assure that they received appropriate alternative care.

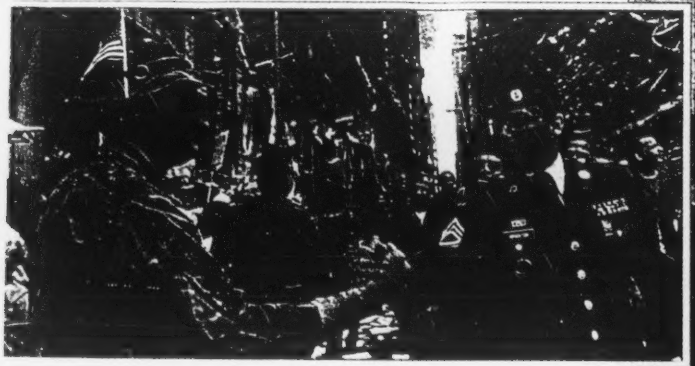
Recommendations to the Administrator of Veterans Affairs

We recommend that the Administrator direct the chief medical director to

- determine whether any outpatient clinic located closer than the current support facility could better provide clinical and training support to a vet center and
- strengthen collaboration between vet centers and PTSD units by requiring these facilities to establish formal communication concerning all clients referred from one to the other.

Agency Comments

In his June 11 letter, the Administrator concurred with both recommendations. By July 31, 1987, he expects to forward guidance to the field (1) instructing vet centers and VA outpatient clinics that are near each other to participate in each other's clinical and training activities and (2) requiring collaboration between vet centers and PTSD units, according to standards of sound clinical practice. The Administrator stated that increased information sharing between the PTSD units and vet centers had already begun, including the participation of vet center staff in PTSD regional conferences.



JODI BUREN—SYGMA

Ten years later, an anniversary parade: *For many veterans, the welcome was too late*

Marines dodge an ammunition-dump explosion

Treating War's Psychic Wounds

Stress disorder among Vietnam vets may be rising

BY DAVID GELMAN

Sometimes you run across individuals who are really still in Vietnam, and you have to walk back to Vietnam with them and walk them back out. I must've been involved with 450 people over three years, and it gets to you.

More times than he cares to remember now, Frank Delfi has taken that walk to Vietnam and back again with stressed-out veterans of the war, trying to help them get their bearings. It was only a few years ago that he himself was grappling with "horrendous" headaches and sleeplessness, symptoms of the post-traumatic stress disorder (PTSD) that had plagued him since his own discharge from the Army in 1968. He had been practically living on aspirin and hoping he could get through a night without the "little dreams" that took him right back to the terrifying chaos of the 1968 Tet offensive. Now, at 41, Delfi is director of placement for the Vietnam Veterans Leadership Program in New York, a privately sponsored therapy and job-counseling program that helped him get his life under control.

To Delfi, the continued anguish of many Vietnam vets is a fact of his daily working life, although he thinks the media sometimes exaggerate the problem. There are those, nevertheless, who have remained sharply skeptical about the authenticity of these psychic casualties of the war, especially the fatigue-clad veterans often photographed weeping at Vietnam memorials. "Excuse me while I barf," wrote one Viet vet in a recent Wall Street Journal op-ed page article that was vigorously seconded by a spate of letters. "The vast majority of men who fought in that war ... simply do not fit any of those images. Many of us are embarrassed by them ...."

Last month, however, the authors of a comprehensive five-year study by the Research Triangle Institute reported to Congress that 15 percent, or about 470,000, of the approximately 3.14 million men who served in Vietnam "are current cases of PTSD." (Around 7,000 women, mostly nurses, were also victims, the study said.) That figure was strikingly higher than the 66,000 total reported a few months earlier by the Centers for Disease Control. The two studies used somewhat different methods, and the discrepancy seemed bound to add tinder to an argument almost as politicized as the debate over the war itself. But the RTI researchers say their own survey, funded by the Veterans Administration, is the "most representative" yet. One difference, they note, is that the CDC asked veterans only about symptoms experienced in the month prior to the interviews.

In fact, some health officials are convinced the incidence of PTSD is actually growing. For one thing, they are beginning to see World War II and Korean War veterans with the symptoms, probably exacerbated by such stressful events as impending retirement, or the death of a spouse. By one estimate, the older vets account for about 30 percent of the patient total. Some have suffered from recurrent dreams of death and dismemberment for 40 years but never sought help until recent media attention made them aware of PTSD.

Through the 1970s, psychiatrists themselves remained divided over the true extent of the problem. But in 1980, after years of astringent controversy, it was finally given a name and included in the diagnostic manual of the American Psychiatric Association (DSM-III). The RTI report indicates there have been major advances in diagnosing PTSD since then. Doctors, nevertheless, are still not sure why some soldiers were hit by the disorder while the majority apparently came through unscathed. "What we need to find out now," says Terence Keane, research coordinator

ATTAChment B

ROBERT J. ELLISON—BLACK STAR

yond the battlefields of Vietnam, the emotional casualties are still being counted

of the RTI study, "is who does and who doesn't develop traumatic response."

PTSD is in the direct line of evolution from "shell shock" and "battle fatigue," names it carried in earlier wars. But those conditions were often short-lived. Doctors have been trying to understand what was different about Vietnam—why so many young survivors of the war seemed unable to reconnect with normal life, some plunging into drugs, alcohol and violence, others hunkering down and withdrawing—living "in a psychic Vietnam," as Dr. Harvey Schwartz, editor of the 1984 volume, "Psychotherapy of the Combat Veteran," characterized a vet he was treating.

One difference was the absence of a warm welcome for returning veterans. Most Vietnam GI's went to the war alone and came home alone, unlike their fathers in World War II who went and returned on troopships, in an aura of heroism, often with bands saluting them at dockside. Another was the age of the soldiers. It has often been said that this was a war fought mainly by the poor, but it was also perhaps our first war fought by adolescents. The average age of the Vietnam fighting man was 19.2 years, compared with 26 in World War II—"the youngest group we have fielded as a nation since the Civil War," according to Walter Penk, director of psychology for the department of mental health in Massachusetts. These were soldiers still in their formative years, a cohort particularly susceptible to the traumatic, terror-filled "imprinting" many of them were later found to have undergone.

For a time, it was thought that a victim had to be predisposed to it by childhood traumas or an unstable family background. But as the current, revised version of DSM-III defines it, it is the result of "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone." The definition is meant to cover not only war trauma but almost every sort of shock, from auto accidents to airplane hijackings. The hallmarks include recurring nightmares, involuntary memories, "hypervigilance"—the feeling of imminent danger—and "flashbacks," a vivid re-experiencing of the event. For some there may also be a long period of numbness in the wake of the trauma, one reason for the delayed reaction often associated with the syndrome.

Working through it: *Art therapy at Palo Alto VA hospital*

JAMES D. WILSON—NEWSWEEK

Doctors have been trying to fight the image of returned veterans as "walking time bombs," waiting to explode at any provocation—a notion promoted in part by press accounts and television shows that never seem to tire of stories about berserk veterans. In truth, though there are no definitive statistics, rates of crime, suicide and drug and alcohol abuse among veterans are known to be high. According to a report released by the House Committee on Veterans Affairs in 1979, more than 400,000 vet were in prison, on probation or parole or awaiting trial. (No later estimates are available.) But while those numbers are disturbing, the average PTSD victim apparently leads a life of quieter desperation.

Moral confusion: The Vietnam War was not only America's first losing war but probably its most unpopular. By early 1968, when the Tet offensive was perceived as a disastrous setback for the U.S. effort, the war was coming under furious attack at home. Many soldiers who started their service then began under a cloud of moral confusion. There was also the very nature of the fighting—sinister guerrilla warfare in which soldiers were often unsure who the enemy was. It was, especially, a war fought without boundaries, spilling over among a civilian population of women and children and constantly tumbling into transgressions. Beyond seeing close "buddies" killed—a shattering loss for adolescents—many GI's took part in atrocities or witnessed them. One veteran tells of seeing his buddies detonate a grenade in a woman's vagina. Another was ordered to throw an old woman down a well, then drop a grenade on her.

There are indications that in many cases of PTSD, some sort of social pathology was already at work. The RTI study, for instance, found the highest rates of PTSD among blacks (19 percent) and Hispanics (27 percent), many from troubled, unstable families. Schwartz recounts the case of "Patient B," a 33-year-old white man who came to a VA clinic for treatment. In the 13 years since his discharge he had been suffering from recurrent nightmares, outbursts of anger, headaches and mental lapses. One of nine children, he had grown up in terror of his brutal father, next to whom he felt small and inadequate. "With excitement and admiration he would describe in detail the power and grandeur of his father's 'tools'," notes Schwartz.

In Vietnam, besides losing many of his buddies, Patient B had one culminating experience: one day he saw a "frail old man" walking along a dike "just carrying a tool" and killed him with a single shot. "No one said anything," he recalled. On the contrary, his lieutenant, who had seen the shooting, promptly claimed it as his own kill, adding to his body count.

Horror stories: For some young soldiers, the treacherous, undefined Vietnam battlefields thus became a kind of free-fire zone of the mind. Under conditions that seemed to suspend the limits of permissible behavior, some GI's played out unconscious and murderous aggressions. They were different from ordinary psychiatric patients, says Schwartz, "because they didn't just fantasize killing a father or mother, they *did* it." Indeed, some of the combat stories doctors have had to listen to are so disturbing that the therapist's ability to hear them out without feeling revulsion for the patient has become an issue in the psychiatric literature about Vietnam veterans. Says Schwartz: "You have to be able to tolerate massive amounts of horrible effect."

Soldiers still of tender years looked to their officers as figures of parental authority who would put the stamp of approval or disapproval on their conduct. But that didn't always happen. Like Patient B's lieutenant, some officers tacitly or even explicitly approved the killing. Then the soldiers came home to a civilian world that sometimes openly reviled them or, in any event, failed to offer them the blessing that returning warriors traditionally have received from their elders. "It was a profound insult, a breaking of the covenant between a nation and its soldiers," says Erwin Parson, a consulting psychologist with the Vietnam Veterans Leadership Program.

Ultimately the soldiers were left with a burden of guilt they couldn't handle. Most therapists agree that unconscious guilt is "central" in the etiology of stress disorder. Buried guilt, fanned by a hostile reception at home, flares into rage; flight from guilt leads to withdrawal, or to the driving restlessness that impels many veterans to jump from job to job.

Parson recalls that years ago he treated a six-year-old boy who had seen his father fatally stab his mother. Misdiagnosed as a schizophrenic and heavily medicated, the boy was distractingly restless. "He kept jumping up and down, rattling drawers, his pencil became a bomber. I would bribe him with cookies to sit still for 10 minutes." One day, about a year and a half into treatment, the boy told the therapist: "When I sit down I get too sad." Parson suddenly understood that the constant movement was the boy's way of managing traumatic stress. "He was shutting memories out by staying in motion. He kept seeing the knife in his dreams. He was having some of the same symptoms as combat veterans. But this was 1975. There was no name for it yet."

Therapists also encounter unconscious "re-enactment" in veterans' behavior, a sort of "combat readiness" mentality that keeps them irrationally on the alert for danger. Fred Gusman, a clinical social worker who heads a specialized VA treatment center for PTSD in Menlo Park, Calif., recalls one former GI telling him he "couldn't stand" to have his wife hold his hand in the Safeway market. "If something goes wrong," he explained, "I need to feel free to react." Eugene Rivera, a former PTSD patient who is now a career training officer at the VVLP, remembers the long nights a few years ago when he would sleep for an hour and stay awake for three. "I was pulling guard duty again," he says. "You start to drift back."

No help: In the recriminatory atmosphere of the post-Vietnam era there was no diagnosis or treatment of stress disorders associated with the war. Like Parson's young patient, stressed-out vets were often labeled schizophrenic or treated strictly for alcohol and drug abuse. Art Blank, a psychiatrist who heads the VA's readjustment counseling service and a Vietnam veteran himself, says it took "a significant political and professional effort just to bring about a basic recognition of the condition. You could almost say there had to be another war fought." When that war was won, in 1979, Congress authorized the VA to open a string of outreach and counseling centers for veterans. There are now 188 storefront centers around the country.

At first there had been a crisis-management approach to PTSD. With new understanding of the problem, a more traditional approach of individual, group and family "talk" therapy evolved. There are special issues of profound mistrust of authority for these vets—mistrust that can center heavily on the therapist. (It helps considerably when the therapist has had some Vietnam experience himself.) But treatment essentially follows the Freudian principle of "remembering, repeating and working through." One vital component, says Terence Keane, who served as research coordinator of the RTI study, is "a systematic and careful exposure" of the original traumatic events. Learning to confront the trauma over a period of time is a major step forward in overcoming PTSD.

Solid proof: By now, according to Art Blank, the VA has treated more than half a million veterans and 150,000 family members. Scientifically, at least, there is little controversy left about the validity of the stress disorder. "It's as solid as anything," says psychiatrist Bessel van der Kolk of the Massachusetts Mental Health Center. "There is a very good animal model of inescapable response. Tortured animals show hyperactivity, hyperarousal, and they continue to react even to minor stimuli as if they were being re-exposed to the same shock."

Health officials now believe that given sufficient stress, anyone can fall victim to PTSD, regardless of family background. Although the disorder tended to strike most heavily at the blacks and Hispanics who largely fought the war, VA centers are beginning to see officers and other veterans from middle-class backgrounds. By no means have all PTSD sufferers come in out of the cold. Uncounted thousands more, among them World War II and Korean War vets, are believed to be still out there, wrestling with their demons. Doctors hope that with help now available, victims will no longer have to carry on their struggle alone. The Vietnam veterans are finally getting the recognition they sought, even if it had to be in illness rather than the triumph of homecoming.

SUDHIR—PICTURE GROUP

Repairing a broken covenant: *Psychologist Parson with patients*

POST TRAUMATIC STRESS DISORDER: IS AN ISSUE FOR ALL VETERANS

Because Vietnam veterans fought to get Post Traumatic Stress Disorder recognized as a specific and genuine psychological condition, some people think of PTSD as a problem peculiar to Vietnam vets. **Actually, about 30% of the PTSD cases** being **treated at present** are **World War II and Korean War veterans.** A Veterans Administration study found that one in eight of the World War II combat veterans and one in ten of the Korean War veterans in mental health outpatient programs have PTSD.

One recent report concluded that there is overwhelming evidence that combat can and does often lead to a syndrome of physiological and psychological symptoms, and that combat-induced distress can last a long time, more than a decade in many cases.

In fact, PTSD is not limited to veterans. The American Psychiatric Association says PTSD results from exposure to "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone."

Victims of auto accidents, hijackings, rape, and terrorist attacks also suffer PTSD. Dr. Erwin Parson, a consulting psychologist with the Vietnam Veterans Leadership Program reported treating a six-year-old boy who developed PTSD after he had seen his father stab his mother. Dr. Parson was a participant in the New York State Temporary State Commission on the Readjustment Problems of Vietnam Veterans national working conference on Post Traumatic Stress Disorder and Chemical Dependency.

Despite the image created by what Newsweek calls "television shows... about berserk veterans," a recent Newsweek article makes it clear that "the average PTSD victim... leads a life of quieter desperation." Like other disabilities, the Veterans Administration rates PTSD cases from 10% to 100% disabled.

Since 1979, when Congress authorized the VA to set up Vet Centers, the VA has treated over half a million veterans and some 150,000 family members. State and local mental health agencies, as well as private institutions and State-supported Veterans Outreach Centers, also offer programs.

"PTSD is being treated successfully," comments Tom Lewis, Director of the New York State Division of Veterans' Affairs. "Our State Veteran Counselors can refer veterans to appropriate treatment programs."

ATTACHMENT D

VETERANS VOICE

STATE OF NEW YORK - EXECUTIVE DEPARTMENT
DIVISION OF VETERANS' AFFAIRS

MARIO M. CUOMO, Governor
TOM LEWIS, Director

Number 1471 * * * October 1988

NEW YORK STATE PTSD CONFERENCE CALLS FOR BROADER TREATMENT APPROACHES

Veterans stress experts attending the National Working Conference on Post Traumatic Stress Disorder and Chemical Dependency among Vietnam Veterans, the first of its kind in the nation, agreed to support programs which call for simultaneous treatment of PTSD and substance abuse. The conference was held by the Temporary State Commission on the Readjustment Problems of Vietnam Veterans.

"There is a strong correlation between PTSD and substance abuse, be it alcohol or drugs or both," said Thomas Brinson, Commission member. "Veterans who 'medicate' themselves with drugs and alcohol to relieve symptoms of combat-related stress face results as dangerous as bombs and booby traps. This interaction can make unemployment, underemployment, incarceration, homelessness, and every other readjustment problem of veterans more serious."

That correlation had not yet been widely recognized either in clinical literature or in treatment programs before the conference began, though PTSD and substance abuse are both recognized as major problems for many veterans.

According to Project Director Vince Treanor, a credentialed Alcoholism Counselor and a former Veterans Administration Vet Center Counselor, "The most comprehensive study ever done on the readjustment of Vietnam veterans, the National Vietnam Veterans Readjustment Study by the Research Triangle Institute of North Carolina, estimates that 15% of all male veterans who served in Vietnam and 9% of all female veterans currently suffer from Post Traumatic Stress Disorder - a direct result of their service to their country in Vietnam. This means about 471,000 people nationwide and at least 21,000 in New York State.

Most current research confirms that the higher the incidence of exposure to combat, the more likely chemical abuse exists. Put together, this often means problems in relationships, work, mental and physical health. The longer these problems go unaddressed, the more at risk the veteran is to suicide.

Medical Center **Northport NY 11768**

Veterans Administration

In Reply Refer To: 632/116B

•March 6, 1989

Mental Health & Behavioral Sciences
Service (116)
VA Central Office
810 Vermont Ave., N.W.
Washington, DC 20420

SUBJ: Solicitation of Proposals for Post-Traumatic Stress Disorder Clinical Teams (PCT's)

1. Enclosed is the request for proposal for PCT at Northport V.A.M.C.

WILLIAM H. MANLEY
Director

ATTACHMENT E

"America is #1—Thanks to our Veterans"

REQUEST FOR PROPOSAL
POST TRAUMATIC STRESS DISORDER CLINICAL TEAM
VAMC, NORTHPORT

I. Program Summary:

Target Population

With some 400,000 veterans, Long Island's Nassau and Suffolk counties contain the largest concentration of veterans per capita in the United States. Of those veterans, 80,000 Vietnam era veterans are within the Northport Medical Center's catchment area. Consequently, there is a large percentage of Vietnam era veterans in the psychiatric units at Northport who could benefit from Post Traumatic Stress Disorder (PTSD) treatment.

Much of the literature published about PTSD suggests that all Vietnam era veterans have PTSD symptoms. At Northport, although they are not diagnosed with PTSD, there are many patients who exhibit PTSD symptomatology and could benefit from treatment. In addition veterans organizations within the community have strongly requested that the unmet needs of veterans suffering from PTSD be addressed in a formal manner.

Currently, the center has minimal resources for treating PTSD, even though the Alcohol Rehabilitation and the Stress Treatment Adjustment and Rehabilitation (STAR) Program consist of 50% Vietnam era veterans. Likewise, one-third of the Day Hospital population consists of Vietnam era veterans, and a significant number of these patients exhibit PTSD. Outside the station, local Vet Centers report that veterans exhibiting PTSD symptomatology will not come to the Northport VAMC because there is no specialized treatment available. Veterans and veterans organizations alike have been outspoken that their PTSD is not being properly assessed or treated.

If a PTSD Clinical Team were established at Northport, there is no question that a large number of veterans would benefit from the specialized services they would receive. These patients could enter the system in a number of ways. From within the hospital there would be referrals from both Inpatient and Outpatient Psychiatric Units, from the STAR Program, (an inpatient substance abuse program focusing on Vietnam Era Veterans) from the Alcohol Rehabilitation Program, from ETA, and from the Day Hospital to the PCT. Outside the station, referrals would come from the Vet Center, the Vietnam Veterans of America and other service organizations.

Although substantial need for appropriate treatment services for PTSD exists in the community, there are certain criteria which would be important to the success of the PCT in providing such treatment. In order for the team to be successful in treating PTSD, patients will have to meed the eligibility criteria of the targeted population. In order to be eligible, patients must (1) be war zone veterans, (2) be capable of and amenable to participating in intensive psychotherapy, and (3) meet the Diagnostic and Statistical Manual III - Revised edition (DSM-III-R) criteria for PTSD.

The exclusion criteria for veterans referred for treatment by the PCT are:

(1) veterans unwilling to abide by the treatment plan, as designed by the PCT,

(2) veterans who have psychiatric disorders which prevent them from integrating into a treatment program,

(3) veterans with severe substance abuse problems who are unwilling to go through substance abuse treatment to become abstinent,

(4) veterans receiving psychotropic medication who refuse to take their medication.

These inclusion and exclusion criteria are vitally important to not only the success of the program but also to meeting the clinical needs of veterans with PTSD. The fundamental clinical need of the population of veterans is the assessment, and specialized treatment of PTSD by clearly identifiable, expert personnel. The creation of such a specialized team of mental health professionals will allow veterans to be properly diagnosed and treated, and more importantly will allow veterans to express their PTSD-related experiences to professionals who veterans perceive will be able to help them. The establishment of a group of dedicated, trained mental health professionals is critical to the treatment of PTSD among Vietnam era veterans. Many veterans are reluctant to focus on their PTSD experiences because of the lack of this perceived expertise of the clinician. This has been evidenced in the Vet Center, in the units at the Medical Center, and by the service organizations. With the establishment of the PCT, veterans are far more likely to choose to discuss their PTSD in the hope of receiving effective treatment for their PTSD symptoms.

Clinical Activities

All relevant and appropriate clinical modalities will be made available to veterans suffering from PTSD through services offered by the PCT. These services will include: (1) behavioral and insight oriented therapies addressing PTSD symptomatology. (2) in depth psychiatric and psychological evaluation. (3) chemotherapy and (4) substance abuse treatment. Referrals from PCT to other needed Medical Center programs such as work restoration and the Vet Center would also be made.

On a monthly basis the anticipated workload of the PCT will be 80 screening interviews, 30 comprehensive assessments, 40 consultations, 150 active treatment cases and 8 educational and liaison activities. None of these activities will be offered on a limited basis.

Integration Strategy

At the Medical Center there is an increased awareness of the need to address PTSD. Much of the staff is in support of a clinical team that will treat PTSD. As a result, integrating such a team into the Center presents little, if any, difficulty. On the contrary, the PCT will be a greatly welcomed addition since it will provide a resource to clinicians which was previously needed but unavailable. Thus, the integration process should be without obstacles. The strategy for integrating the PCT with our existing resources will be to appoint a representative member of the PCT to the executive committee of the Mental Health Council. The Mental Health Council has long been a forum for discussion of the need for a PTSD Clinical Team and will be an appropriate arena for the continued discussion of how best utilize the PCT. In addition, this representative of the PCT will also be a member of the Vietnam Veterans Clinical Coordinating Committee, a multi-disciplinary committee which coordinates treatment resources for PTSD between the Northport VAMC and the affiliated Vet Center.

Other than the Vet Center, there are minimal existing resources within the community available for PTSD treatment. These resources include the State Psychiatric Center System, the affiliated SUNY Stony Brook University Hospital and other private and community mental health organizations. The Northport VAMC works closely with the Vet Center in nearby Babylon. The Chief of Psychology regularly attends meetings at the Vet Center and serves as a liaison and clinical consultant to the Vet Center. Close collaboration with the state psychiatric system and University Hospital is not as well maintained as it is with the Vet Center. Such a relationship, however, could easily be established with not only the State and with University Hospital, but also with other private and community mental health organizations.

Since Northport is a large facility where beds have been significantly reduced over the past 15 years,, there is a large amount of unoccupied office space available for the PCT. In addition, telephone service, custodial support, computers, and other ADP capabilities are easily obtainable and would be provided willingly if the PCT were established at Northport.

II. Administrative Summary:

The Psychology Service in consultation with the Psychiatry Service will be responsible for the implementation and ongoing operation of the PCT. The Vietnam Veterans Clinical Coordinating Committee for PTSD will be the advisory group for the operation of program development for the PCT.

PCT Staff will receive reimbursement for the use of their personally owned vehicles in the treatment and assessment of PTSD. In addition to this support, the Northport VAMC will provide any clinical and/or administrative support necessary to maximize the PCT's effectiveness and treatment efforts.

The following non-recurring funds will be needed to activate the PCT in fiscal year 1989:

1. Furniture

Item	Quantity	Unit Cost	Total Cost
Office			
Desk	4	300	1200
Credenza	4	340	1360
Files (2 drawer lateral)	4	150	600
Bookcases	4	100	400
Desk Chairs	8	100	800
Guest Chairs	8	85	680
Bulletin Boards	4	50	200
Waiting Room			
Lounge Chairs	8	250	2000
Corner Tables	4	120	480
Coffee Tables	2	160	320
Miscellaneous			
Reception Desk	1	450	450
Secretary Chair	1	100	100
Files (3 drawer lateral)	2	250	500
Bulletin Board	1	80	80
Drapery			2000
Carpet			3000
Artwork			1200
		Sub-Total	$15,370

2. Equipment	
Universal Gym	1,500
3. Telecommunications	
Installation	520
4. Training Materials (books, audio-visual materials, etc.)	2000
Summary: Nonrecurring Costs	
Furniture	15,370
Equipment	1,500
Telecommunication	520
Total Cost:	$19,390

III. Staff and Implementation Timetable

The recruitment period for the PCT will be approximately one to two months. We anticipate that treatment and consultation would be simultaneous to developing the program in further detail. In sum, the PCT would be fully operational by July 4, 1989.

There is ample staff at the Northport VAMC who would be potential internal candidates who might apply for positions on the PCT. Some of these mental health professionals include:

1. Name: Barbara Albanase
   Credentials: MSW
   Mental Health Treatment Experience:
   PTSD Assessment/Treatment Experience:
   Experience in the VA System:
   Experience with community organizations:

2. Name: Christopher R. Carlson
   Credentials: Clinical Psychologist, Ph.D.
   Mental Health Treatment Experience: Clinical Psychologist, 13 years, VAMC Northport.
   PTSD Assessment/Treatment Experience: Director, Special Inpatient Unit for Vietnam era veterans, 5 years
   Experience in the VA System: Staff Psychologist, 5 years,; Chief, Psychology Service, 8 years.
   Experience with community organizations: Liaison to Vet Center, 8 years.

3. Name: Gasper Falzone
   Credentials: MSW
   Mental Health Treatment Experience: Social Work Specialist, U.S. Army, (Vietnam) 1 year; Social Worker, Pilgrim State Hospital, 9 years.
   PTSD Assessment/Treatment Experience: Team Leader, Vet Center, 8 years.
   Experience in the VA System: Team Leader, Vet Center, 8 years.
   Experience with community organizations: Team Leader, Vet Center, 8 years.

4. Name: Robert Hackett
   Credentials: RN
   Mental Health Treatment Experience: Psychiatric Nurse, Long Island Jewish Hospital, 7 years; Army Reserve Nurse Corps, 9 years.
   PTSD Assessment/Treatment Experience: Volunteer Facilitator, Vet Center 3 years.
   Experience in the VA System: Volunteer Facilitator, Vet Center; Assistant Head Nurse, Substance Abuse, Northport VAMC, 3 years.
   Experience with community organizations: Volunteer Peer Group Co-facilitator, Vet Center, 6 years.

5. Name: Jack Hirschowitz
   Credentials: MD (Board Certified)
   Mental Health Treatment Experience: Staff Psychiatrist, William Salter Hospital for Alcohol and Drug Dependency, Cape Town, South Africa, 1 year. Assistant Medical Director, Alcohol and Drug Dependency Unit Blue Hill Hospital, Hartford, Connecticut, 2 years. Psychiatrist, University of Cincinnati, University Hospital, Research and Consultation, 6 years. Chief, Psychiatry Service, VAMC Northport, 3 years.

6. Name: Eugene Jarzcynski
   Credentials: Chaplain
   Mental Health Treatment Experience: Clinical Internship, St. Elizabeth's Hospital, Washington, D.C., 1 year; Catholic Chaplain, Wilkes-Barre, VAMC, 2 years; Chaplain/Group Facilitator, Substance Abuse Treatment Units, Northport, VAMC, 10 years.
   PTSD Assessment/Treatment Experience: Group Facilitator, Vietnam Group, Substance Abuse Treatment Group, VAMC Northport, 7 years. Chaplain, U.S. Air Force, 12 years including 1 year service in Vietnam.
   Experience in the VA System: Chaplain, VAMC Wilkes-Barre 2 years; Chaplain, VAMC Northport, 10 years.
   Experience with community organizations: Volunteer Counselor, Long Island Alcohol Council, 1 year.

7. Name: Ganesan Krishnamurthy
   Credentials: MD
   Mental Health Treatment Experience: Staff Psychiatrist, Central Islip State Hospital, 10 years; Staff Psychiatrist, VAMC Northport, 8 years.
   PTSD Assessment/Treatment Experience: 10 years inpatient/outpatient evaluation.
   Experience in the VA System: Psychiatrist, VAMC Northport, 8 years.

8. Name: Jaedu Lee
Credentials: MD
Mental Health Treatment Experience: Psychiatrist, High Point Hospital, Port Chester, NY, 5 years; Psychiatrist, VAMC Northport 13 years.
PTSD Assessment/Treatment Experience: Consulting Psychiatrist, Young Veterans Program (Special Inpatient Unit for Vietnam Veterans).
Experience in the VA System: Psychiatrist, Mental Hygiene Clinic, Inpatient Admissions, VAMC Northport, 7 years

9. Name: Leroy Monroe
Credentials: Clinical Psychologist, Ph.D.
Mental Health Treatment Experience: Staff Psychologist Rockaway Mental Health Center, 6 years. Staff Psychologist VA Medical Center, Northport,(Alcohol Rehabilitation Program),2 years. Program Director Stress Treatment and Rehabilitation Program (STAR) VA Medical Center, Northport, 2 years.
PTSD Assessment/Treatment Experience: Program Director (STAR) Program evaluation and treatment of Vietnam veterans, 2 years.
Experience in the VA System: 1984-1989 Psychologist, VAMC Northport, 5 years.
Experience with community organizations: Staff Psychologist, Rockaway Mental Health Center, 6 years.

10. Name: Joseph Mazzo
Credentials: LPN
Mental Health Treatment Experience: November 1972-1982 spent between Surgical Unit & ETA. 1982-1984 spent as patient representative. MHC/OPD 63 1987 to present.
Experience with community organization: LIAAC.

11. Name: Jeanne Morrison
Credentials: MSW
Mental Health Treatment Experience: YMCA Family Services, 3 years; Readjustment Counselor Vet Center, 3 years.
PTSD Assessment/Treatment Experience: Private Practice, 3 years; Readjustment Counselor Vet Center, 3 years.
Experience in the VA System: Readjustment Counselor Vet Center, 3 years.
Experience with community organizations: Project Director, YMCA, 3 years, developed community counseling programs; Vet Center Outreach Services 2 years.

12. Name: Anthony Verga
Credentials: MD (Board Certified)
Mental Health Treatment Experience: Staff Psychiatrist, VAMC Northport, 10 years.
PTSD Assessment/Treatment Experience: Assessment-2 years Admitting Psychiatrist. Treatment eight years Inpatient/Outpatient Psychiatry.
Experience in the VA System: Ten years, VAMC Northport.
PTSD Assessment/Treatment Experience: Eleven years treatment and evaluation. Experience in the VA System: Three years, Chief, Psychiatry Service.

Because of the experience which internal staff possess with regard to PTSD assessment and treatment, the Northport VAMC will be able to begin an effective, cost efficient PCT within a short period of time. In addition, because of the availability and proximity of the Northeast Regional Medical Education Center (NE-RMEC) training for PCT personnel would be expedited. Members of the staffs at both Northport and the Vet Center have already been trained for PTSD treatment through the NE-RMEC.

IV. Program Development

The Planning Committee for the PTSD Clinical Team includes the following people:

Name	Position	Discipline
Christopher R. Carlson, Ph.D.	Chief, Psychology Service	Psychology
Jack Hirschowitz, MD.	Chief, Psychiatry Service	Psychiatry
Rick Smith, CSW, CAC	Director, Alcohol Rehabilitation	Psychiatry
Vivian Bugaoan, MSW	Supervisor, Social Work	Social Work
Al Carvalheira, RN	ACN, Psychiatry	Nursing
Gasper Falzone, CSW	Team Leader, Vet Center	Psychology
Chuck Monroe, Ph.D.	Director, STAR Program	Psychology
Shari Liss	Health Systems Specialist	Director's Office
Peggy Treacy	Management Assistant	Director's Office

The data which guided the planners in defining the goals and objectives of the PCT were the needs of veterans with PTSD as identified by clinicians working in the hospital units. In addition, the direct experience of the PCT Planning Committee and the direct input from veterans and veterans groups in the community strongly influenced the Planning Committee in defining goals and objectives. At monthly Veterans Advisory Council meetings veterans have repeatedly inquired about services that are to be provided for veterans with PTSD. Likewise, Vet Center staff have indicated the need for specialized PTSD treatment from veterans who they see at the Vet Center.

There are no significant obstacles anticipated in the establishment of the PCT. The New York metropolitan area has an excellent availability of highly qualified potential staff. Since recruitment of suitably qualified and interested mental health professionals is critical to the success of the PCT, the New York metropolitan area should provide ample number of qualified applicants. Thus, the time frame for recruitment will be about one month, with any potential recruitment problems being resolved within that time frame.

If you have any further questions, Christopher R. Carlson, Ph.D. will be available at FTS 261-4400 ext. 2260 or 2261.

Post-traumatic Stress Disorder Program

Northport VAMC

Introduction

This is a proposal for the establishment of a Post-traumatic Stress Disorder (PTSD) Program on the grounds of the VAMC at Northport. Specifically, this program would be designed to treat those veterans exhibiting PTSD symptomatology. Administratively, under the aegis of the Psychiatry Service, the 20 bed PTSD Program will operate as a total therapeutic milieu wherein the psychological, interpersonal and social difficulties associated with this disorder may be addressed and treated. This proposal explains the rationale and objectives and describes the struture, functioning, material and staffing needs for the proposed PTSD Program.

I. Mission Statement

A. Rationale

Although American involvement in Vietnam terminated in 1975, America's relationship with the Vietnam War is far from over. According to recent figures, as many as 700,000[1] Vietnam era veterans have suffered severe psychological disturbances as a result of their participation in this conflict. A specific form of such disturbances which many Vietnam era veterans present with has been identified as Post-traumatic Stress Disorder. Symptoms associated with this disorder include reexperiencing the war, numbing of responsiveness, hyperalertness, sleep disturbances and experiencing profound guilt feelings. The disorder impacts upon the psychological, social, interpersonal, vocational, and familial relations of these veterans, and the PTSD Program has been designed to address all of these areas.

B. Needs Assessment

A needs assessment was conducted at the Northport VAMC to determine the existance and extent of differences between Vietnam era veterans and other veterans residing within the catchment area of the Northport VAMC. The results of a questionnaire completed by 486 veterans indicated that, compared with World War II and Korean veterans, a significantly greater percentage of Vietnam era veterans reported experiencing the symptoms of PTSD. They also reported more situational adjustment problems. A great number of Vietnam era veterans expressed a need for psychotherapy and anger-control therapy, and they generally preferred to be treated with other Vietnam era veterans who have had similar combat experiences. (See attached publication, Appendix A). In general, the results of the needs assessment indicate that a significant number of Vietnam era veterans residing within Northport's catchment area would immediately benefit from the activation of a PTSD program. Professional staff at the affiliated Veteran's Outreach Center lend further support to the need for such a program by repeatedly asserting that a significant proportion (approximately 25%) of their clientele would

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[1] Blank, A.S. "Apocalypse terminable and interminable: Operation Outreach for Vietnam Veterans." Hospital and Community Psychiatry, 33, 913 - 918, 1982.

ATTACHMENT E

clearly benefit from participation in a PTSD program. In addition, a similar proportion of the Vietnam era veterans residing in the district and region also are probably experiencing PTSD symptomotology to a degree severe enough so as to have a negative impact upon their psychological, social, and familial lives. Thus, there exists significant numbers of Vietnam era veterans, both within the Northport catchment area, the District, and the Region so as to warrant the establishment of a PTSD Program at the Northport VAMC.

C. Goals and Objectives

1. Clinical

a. Goal: The goal of the PTSD Program is to provide intensive and comprehensive treatment to those veterans who are diagnosed with PTSD.

Objective 1: To provide a measurable reduction in the frequency and severity of re-experiencing the trauma, as indicated by:

a) a reduction in the incidence and severity of intrusive recollections of the event, as measured by patient reports.

b) a reduction in the incidence and severity of recurrent dreams of the traumatic event, as measured by patient report.

c) a reduction in the incidence of acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus, as measured by patient and significant other reports.

Objective 2: To both reduce psychic numbing and increase involvement with the external world, as indicated by:

a) an increase in interest in one or more significant activities, which will be assessed on a weekly basis by the Recreation Therapist.

b) a decrease in feelings of detachment or estrangement from others, as measured by both patient and therapist reports.

c) a decrease in constricted affect, as measured by patient, therapist, and significant other reports.

Objective 3: To reduce the frequency and severity of the behavioral and cognitive symptoms associated with PTSD, as indicated by:

a) the elimination of hyperalertness or exaggerated startle response, as measured by program staff.

b) a decrease in or the elimination of sleep disturbances, as measured by patient report.

c) a decrease in or the elimination of guilt about surviving when others have not, or about the behaviors engaged in which were required for survival, as measured by patient and therapist reports.

d) a reduction in memory impairment and trouble concentrating, as measured by patient report.

e) the elimination of the avoidance of activities that arouse recollection of the traumatic event, as measured by patient and significant other reports.

f) the elimination of the intensification of symptoms by exposure to events that symbolize or resemble the traumatic event, as measured by patient and significant other reports.

g) the elimination of significant drug or alcohol problems, as measured by patient and therapist reports.

Objective 4: To improve the patient's relationship with his or her significant other, as indicated by:

a) the elimination of dangerous behavioral patterns, i.e., physical abuse, if such has occurred in the past, as measured by patient and significant other reports.

b) an improvement in the communication between patient and significant other, as measured by patient, significant other, and therapist reports.

c) an improvement in the quality of sexual relations, as measured by patient and significant other reports.

Objective 5: To improve the relationship between the patient and his or her children, as indicated by:

a) the elimination of dangerous behavioral patterns, i.e., physical abuse, if such has occurred in the past, as measured by patient and child reports.

b) an improvement in the communication between patient and child, as measured by patient, child, and therapist reports.

c) an increase in the amount of time the patient expends with his or her children in recreational activities, as measured by patient, significant other, and child reports.

Objective 6: To improve the patient's occupational/vocational situation, as indicated by:

a) obtaining appropriate employment, as measured by the Vocational Rehabilitation Therapist.

b) maintaining employment, as measured by patient report.

c) maintaining appropriate interpersonal relationships with superiors and co-workers, as measured by patient report.

2. Research

a. Goal: The goal of the PTSD Program is to develop an active research component wherein relevant research information will be collected and research may be conducted.

Objective 1: To maintain a PTSD research resource center which contains the latest published relevent research, as indicated by:

a) the presence of multiple copies of empirical materials published on the diagnosis, etiology, course, and treatment of PTSD, to be monitored on a monthly basis by a designated staff member.

b) the presence of an up-to-date listing of professionals actively engaged in PTSD research, to be monitored on a bi-monthly basis by a designated staff member.

Objective 2: To conduct PTSD research, as indicated by:

a) the initiation of at least 25% of the research projects described in Section X, "Research Activities" of this proposal within the first year of the program's operation, to be measured by the Program Chief.

Objective 3: To conduct formalized evaluation of the program, as indicated by:

a) determining, for each patient, if clinical objectives previously specified have been met. This is to be done both during treatment and at follow-up by a designated staff member, according to the procedure outlined in Section VIII of this proposal.

b) determining, on an annual basis, if the Research and Educational objectives of the program have been met in accordance with the procedure outlined in Section VIII of the proposal.

3. Education

a. Goal: The goal of the PTSD Program is to become a resource for persons desiring to learn about PTSD.

Objective 1: To assure that PTSD program staff receive the latest information regarding PTSD, as indicated by:

a) their participation in relevant conferences and workshops, both within and outside of the VA, to be monitored on a quarterly basis by a designated staff person.

b) the procurement of multiple copies of relevant reading materials, monitored on a monthly basis by a designated staff person.

Objective 2: For PTSD Program staff to actively educate other health care providers and other professionals about the disease and its related features as indicated by the quarterly monitoring of all of the following activities by a designated staff member:

a) staff members speaking at conventions, conferences and workshops.

b) staff members speaking to professions within the Northport VAMC and other VAMCs within the region.

c) staff members speaking at universities and colleges.

d) staff members speaking with various public and private agencies within the community.

Objective 3: To educate community members, especially veterans and their families, about PTSD and its effects, as indicated by:

a) staff members speaking at the local Vet's Outreach Center.

b) staff members speaking to various veterans groups.

c) staff members collaborating with the External Affairs Coordinator in preparing materials to be released to the press.

II. Description of Program

A. Administration

The program will be administered by the Program Chief, who will be a psychiatrist, psychologist, or other mental health professional, to be selected on the basis of specialized skills and experience. The staff, to be described below, will be professionally responsible to their service chiefs, but will be directly responsible to the Program Chief. Administratively, the program will be a part of the Psychiatry Service.

The Program Chief will take major responsibility in representing the PTSD Program to medical center management, as well as to clinical and administrative services. Active ties with the Vietnam Veteran Outreach Center will also be maintained. It will be the responsibility of the Program Chief to ensure the quality of care provided, and to see that the objectives of the PTSD Program are indeed being carried out.

B. Patient Description/Load

Inpatient Unit:

Total number of patients per day - 20

Average length of stay - 90 days

Patient Criteria:

PTSD Diagnosis (See Appendix B)

Outpatient (Aftercare):

Number of participating patients at any one time - 20 - 30

Length of treatment - 6 months

Patient Criteria:

Regular discharge from the PTSD Program

C. General Organization

The organizational structure of the PTSD Program takes the form of matrix organization, and is shown in the Organizational Chart (See Appendix C). The Chief of the Program will be clinically responsible to the Psychiatry Service, and professionally responsible to the service of his or her discipline. In additional to being supervised by the Chief of the Program, the staff will be professionally responsible to their respective professional services. All support services available at the Medical Center will be utilized on a consulting basis when necessary.

III. Staffing

A. Staffing Requirements

The staffing for the PTSD Program is as follows:

Position	FTE
Psychiatrist*	.5
Psychologist*	1.0
Social Worker*	1.0
Psychology Technician	1.0
Head Nurse	1.0
Registered Nurse	6.0
Licensed Pratical Nurse	6.0
Nursing Assistant	6.0
Vocational Rehabilitation Therapist	1.0
Recreation Therapist	.5
Secretary	1.0
TOTAL FTE	25.0

* One of these individuals will be designated as Program Chief.

B. Responsibilities of Staff

A list of each staff position and a description of the main responsibilities of that position follows.

Program Chief: The Program Chief's responsibilities will be both clinical and administrative in nature. This person will collaborate with staff members in both the planning and delivery of treatment. The Program Chief will also continuously monitor the PTSD Program as a whole, to ensure that the therapeutic milieu is maintained, and that a supportive atmosphere exists at all times for patients and their families or significant others. The Program Chief will coordinate and supervise the program evaluation activities, and the clinical duties of the Program Chief will include conducting community meetings and psychotherapeutic groups, as well as providing individual and family therapy to appropriate patients.

Psychiatrist: The psychiatrist will provide psychiatric evaluation and medical evaluation to program participants, and will prescribe medications as appropriate. The psychiatrist will also participate in other treatment modalities provided through the program.

Psychologist: The psychologist will conduct formalized psychological assessments of the patients. The psychologist will provide a variety of psychotherapeutic services to the veteran, including individual, group, family, and behavioral therapies.

Social Worker: The social worker will make assessments of patients' family systems and provide psychotherapy to patients and their families. The social worker will also coordinate discharge planning and will maintain a file of community resources for patients and their families.

Registered Nurses: The registered nurses will participate in the screening of patients and will work with the psychiatrist in determining the need for psychiatric and medical medication. Registered nurses will also participate in treatment planning, and will provide psychotherapy for patients and their families.

Psychology Technician: The M.A. level psychology technician will conduct therapeutic activities under the supervision of the psychologist and Program Chief. Such duties include conducting special topic groups, in addition to acting as facilitators in primary and other treatment groups. The psychology technician will also perform the program evaluation activities, under the direct supervision of the Program Chief.

Licensed Practical Nurses/Nursing Assistants: These nursing personnel will perform nursing care procedures and functions as assigned by the registered nurses. They will also participate in program activiites, including community meetings and psychotherapy groups, and they will interact with patients and their families in a manner consistent with the therapeutic milieu environment.

Vocational Rehabilitation Therapist (VRT): The VRT will be responsible for assessing patients' vocational history and status. The VRT, in conjunction with the patient and his or her significant other, will explore the vocational options which are available to the patient. The VRT will then assist the patient in meeting his or her vocational goals.

Recreation Therapist (RT): The RT will coordinate group recreational activities and will devise and implement a comprehensive program of therapeutic recreation for patients by consulting with the treatment team and patients regarding the therapeutic use and benefit of various recreational activities.

Secretary: The secretary will perform the clerical activities of the program, including typing of correspondences and reports. The secretary will also act as a receptionist, greeting families and visitors, and will schedule patient appointments throughout the medical center.

IV. Program Activities

A. Clinical Activities

1. Inpatient PTSD Program

The PTSD Program will function as a therapeutic environment wherein patients will receive support, encouragement, and confrontation from staff members and each other. A description of the specific therapeutic activities follows:

a. Individual Psychotherapy: all patients will be assigned, upon admission, to a member of the treatment team who will serve as their primary therapist. That staff member will provide regular individual therapy sessions according to a schedule based upon the patient's treatment plan.

b. Primary Group Therapy: ~~upon admiss~~ion, patients will be assigned to one of two ongoing therapy groups. Therapy groups will meet four times a week. The focus of the group will be on developing a cohesive, supportive milieu in which patients will be able to explore and reexperience the traumatic events associated with their disorder. Much of the group's work will be focused on past traumatic experiences, but the relationship of these past experiences with present situations will also be explored.

c. Community Meeting: this meeting will be attended by all patients and staff on the unit, and will be held three times per week. The agenda for this meeting includes administrative issues concerning the operation of the unit, as well as the interpretation and resolution of interpersonal conflicts between patients or between patients and staff members.

d. Peer Group (Leaderless): these groups will meet daily, during the same time period in which the staff meeting is held. Participation in this group serves to strengthen the bonds between patients and contributes to the total therapeutic milieu, by fostering the patients' awareness of their own strengths and resources.

e. Partner's Group: the spouses or significant other of all patients are encouraged to participate in this group, which will meet one night per week. The group will be primarily supportive in nature. Issues which will be dealt with include the veteran's Vietnam experience - from combat to homecoming, the relationship of the Vietnam experience to the present, and the various manifestations of PTSD. Partners will examine the impact of PTSD on their personal and family life, and different methods of coping will be explored.

f. Couple's Group: approximately 6 - 8 weeks after veterans and their partners have been in treatment, they are eligible to participate in the Couple's Group, to be held one night per week. A goal of this group is to foster among couples an understanding of the unique role which each individual has been in. Partners enter the group knowledgeable of the Vietnam experience; in the Couple's Group they learn how this experience is currently affecting the veteran and the relationship. The Couple's Group is the arena where veterans may gain an understanding of the effect that their behavior has had upon their partners and families. This process may be painful for both members of the couple, but after a mutual understanding has been reached, possible plans of action may be discussed and explored. The Couple's Group will also provide the therapist with an opportunity to observe the communication style of each couple, and methods of improving communication will be suggested and appropriately reinforced.

g. Special Topics Groups: time-limited groups, dealing with special topics, will be conducted at regular intervals. These groups will be held in the evenings, and attendance is voluntary. Such topics include, but are not limited to stress management, the psychology of women, and assertiveness training.

h. Vocational Activities: the vocational status of all patients will be assessed upon admission. Vocational deficits will be idenfified and vocational goals will be formulated. Specific activities which will be performed by the VRT and patient will include vocational testing, resume writing, and practice interviews.

i. Recreational Activities: the Recreational Therapist will coordinate the structured recreational activities to be held both on and off the unit on a regular basis. A variety of activities will be offered, so that every patient will be able to engage in meaningful recreational activities during leisure time.

j. Drug and Alcohol Screens: it is expected that many patients on the unit will present substance abuse problems. In order to enforce drug and alcohol abstinence during hospitalization, random drug screens and breath tests will be conducted on the unit. In most cases, drug abuse will result in a patient's discharge from the program.

2. Outpatient Activities - Aftercare

Upon regular discharge from the unit, all patients are expected to complete the six month Aftercare Program. The aftercare activities will occur in the evenings, and for the majority of patients, participation in a group is all that will be required. Partners will be encouraged to continue their participation, as members of the Aftercare Partner's Group and/or the Aftercare Couple's Group. A limited amount of individual therapy will be available, but it is anticipated that this will only be necessary during periods of crisis. During Aftercare, patients will be educated regarding the various support systems available, both within and outside of the VA. Following participation in Aftercare, patients will be considered discharged from the program. If a need for further treatment still exists, the appropriate referals will be made.

3. Involvement with other Medical Center Programs.

Because many patients exhibiting PTSD can be expected to present with a multitude of problems, the staff of the PTSD Program will maintain active ties with all appropriate Medical Center Programs. In this way, PTSD patients may benefit from involvement with other specialized programs, such as:

a. Work Restoration Program: this program is designed to aid veterans in obtaining appropriate employment. Through a multidisciplinary approach, it enables veterans to become aware of their skills, recognize their limitations, utilize appropriate vocational evaluations and training resources, and receive job placement assistance.

b. Alcohol Dependency Treatment Program (ADTP): since many patients of the PTSD Program may also be alcohol dependent, PTSD staff will consult with ADTP staff on a variety of clinical issues. When appropriate, and subject to the approval of the ADTP Coordinator, PTSD patients may avail themselves of selected activities of the ADTP, e.g. Alcoholics Anonymous meetings, etc.

c. Day Hospital Program: upon their discharge from the PTSD Program, a small minority of patients would be expected to benefit from participation in the Day Hospital Program. This program provides a cost-effective method to provide intensive psychotherapy for patients who are no longer in need of inpatient treatment. When a PTSD patient is referred to the Day Hospital Program, the patient's primary therapist will provide input and treatment recommendations to the Day Hospital Program multidisciplinary team.

B. Administrative Activities

1. The Chief of the PTSD Program will meet regularly with Vietnam veterans Outreach staff and other relevant VAMC personnel.

2. The Chief and Staff of the PTSD Program will visit other VAMCs in the district to orient them about the program.

3. Staff meetings will be held on a daily basis so as to discuss treatment planning and program functioning. This will also be the forum for staff to discuss their reactions and feelings about the program and its participants, so as to prevent or identify and treat staff burnout.

4. Staff Feedback Meeting: one staff meeting per week will be devoted to issues of team functioning and relations among staff members. It is expected that the atmosphere on the unit will likely be intense and stressful, and this meeting will provide an opportunity for staff members to provide mutual support and resolve potential conflicts that may diminish the team's effectiveness.

V. Admission Procedure

Patients may be referred directly from the ETA or from other areas of the medical center. Patients may also be referred from the affiliated Vet Center or elsewhere outside the medical center. All patients will be screened prior to admission by program staff to ensure that they present symptoms of PTSD and will benefit from treatment on the unit.

VI. Diagnosis and Treatment Plan

Diagnosis and treatment planning will be the function of the interdisciplinary team (consisting of all PTSD Program staff), in conjunction with the patient and patient's primary therapist. Each patient will be assigned a primary therapist who will work with the patient in developing a treatment plan, and who will also make a diagnostic assessment of the patient. The primary therapist will consult with the treatment team for assistance in performing these tasks with their patients, and the treatment team will have the final authority to approve treatment plans. In most cases, this will be performed via a consultation with the treatment coordinator, who has already familiarized him or herself with the patient.

Each veteran admitted to the PTSD Program will be expected to make a treatment plan with his or her treatment coordinator during the first several days in the Program. The treatment plan will be written and signed by both the veterans and the primary therapist. Treatment goals will include behaviorally observable changes, as well as subjective treatment outcomes. Treatment will be time-limited, and the time schedule for attainment of a veteran's goals will be included in the treatment contract. The majority of veterans will remain inpatients on the Program for 90 days.

VII. Discharge, Follow-up and Referral

Discharge planning will begin at the time the patient is admitted to the Northport VAMC. The Discharge Planning Team, consisting of the Social Worker and the treatment team will meet regularly to discuss the proper plan of discharge of individual patients.

All patients receiving regular discharges will be expected to participate in the six month aftercare program. Upon completion of these activities, patients may join the Alumni groups. Patients in further need of treatment will be given appropriate referrals.

VIII. Program Evaluation Plan

The Program Chief will be responsible for coordinating Program Evaluation activities. The Program Evaluation will be designed to utilize the Goal Attainment Scaling Technique which will assess program effectiveness. This plan will utilize the overall program Mission Statement and Objectives as stated in this proposal. Goal attainment scales will be developed by the staff based on the objectives. From these scales, goal attainment scores will be computed for each objective and an overall program performance index will be generated by aggregating the individual scores. In addition, data on other indicators of program effectiveness, such as cost per patient per day, diagnoses, etc., will be gathered and correlated with this index.

Program goals will be evaluated in a formative process. Goal evaluation will be assessed at regular intevals to provide feedback to the Program Chief and Hospital Administrators, in order to shape and influence the direction and growth of the Program.

IX. Quality Assurance

The Program Chief will be responsible for conducting Quality Assurance activities as mandated by JCAH. In general, quality assurance consists of utilizing a problem-focused approach as outlined below:

1. Problem identification
2. Assessment
3. Problem correction
4. Problem correction monitoring (followup)
5. Documentation

Documentation of Quality Assurance activity will be provided quarterly by the Program Chief through a report submitted to the Chief of Staff via the HSRO Coordinator. The quarterly report will consist of the following:

1. Data reviewed
2. Problems being addressed
3. Problems requiring further study
4. Actions taken or planned
5. Status of any previously identified problem not yet resolved

X. Research Activities

Various research studies will be conducted once the program is activated. Because there are so few PTSD Programs in the country, the Administration at Northport VAMC supports the operation of an active research component of the PTSD Program. The relative dearth of professional literature pertaining to PTSD further supports the need for a PTSD Program with an active research program which collaborates with professionals both within and outside of the VA. Although various research proposals have not been solicited at this time, Northport VAMC personnel have expressed strong desires to design and execute research examining PTSD. Several proposals which are currently being considered include:

1. Assessing the efficacy of a specialized PTSD Program in the treatment of PTSD.
2. Determining the effect of PTSD upon the partners and children of patients.
3. Identifying variables which have substantial impact upon outcome.
4. Examining the role of social support in the development of PTSD.
5. Examining the role of social support in the treatment of PTSD.
6. Examining the impact of treatment upon the associated features of the disorder.
7. Assessing the efficacy of the aftercare component of the PTSD Program.
8. Assessing the outcome of the program at various intervals, both short and long term.
9. Assessing the role of substance use and abuse in the development and treatment of PTSD.
10. Identifying variables which might predispose individuals to develop PTSD.
11. Examining the effect of various stress - reduction techniques in the alleviation of primary and secondary symptomatology of PTSD.

XI. Educational Activities

Affiliated training programs in Psychiatry, Psychology, Social Work and Nursing will be involved in the Program. In addition, both staff and patient educational activities will be encouraged. Educational activities in which staff members would participate include attending conferences and workshops, as well as speaking to professional groups about PTSD treatment. To assure that the program will be appropriately and fully utilized by other services within the Northport VAMC, the Chief of the Program and his or her designates will orient the Medical Center personnel to the program. The chief will also educate relevant personnel in other VAMC's within the region. Patients of the program will be educated by all staff members in the various methods of symptom relief, as well as being taught how to identify and use support systems within the community.

Medical Center Northport NY 11768

Veterans Administration

APR 06 1989

In Reply Refer To: 632/00

Office of Geriatrics and
Extended Care (181B2)
VA Central Office
810 Vermont Avenue, NW
Washington, DC 20420

THRU: Regional Director (10BA1)
Northeastern Region
P.O. Box 8500
Albany, NY 12208

SUBJ: Domiciliary Care for Homeless Veterans (DCHV) Program

1. The problem of homelessness in the New York metropolitan area is one which the Northport Medical Center staff addresses regularly. The Northport Medical Center has provided a variety of services to homeless veterans through its Social Work Service, Psychology Service, and Psychiatry Service. Through Social Work Service intervention, veterans were assisted in securing residences appropriate to their level of functional ability, psychosocial needs, or needs for supervised living. During 1988, 685 homeless veterans received assistance from the Northport Social Work Service, and during the month of January 1989 alone, 77 veterans received assistance. Clearly, a domiciliary at Northport would be able to serve not only the large homeless population of Long Island, but also possible referrals from the other metropolitan VA Medical Centers.

2. Building number 6 is a three story brick structure constructed of reinforced concrete frame and non-load-bearing walls. This building contains approximately 55,000 square feet. The building is virtually empty but is partially reconditioned inside. The original metal and wood window frames are still in place and need to be replaced. The roof is asphalt shingles in good condition but the wood soffit and trim are in poor condition and need painting. Sprinklers have been installed at all floors but are not operable. We believe this building could be renovated to accommodate domiciliary patients. The few services in the building at this time could be relocated. The Facility Development Plan for Northport would also make other building stock available, but not for another 4 to 5 years. Building 6 could be looked to for immediate adaptation to this use.

3. Cost of renovation for domiciliary use is approximately $2,000,000. Estimated time required for renovations is twelve months.

William H. Hanley
WILLIAM H. HANLEY
Director

"America is #1—Thanks to our Veterans"

ATTACHMENT F

DIAGNOSTIC RADIOLOGIC TECHNOLOGIST

Effective April 12, 1987

GRADE	1	2	3	4	5	6	7	8	9	10	AMOUNT OF STEP INCREASE
GS-5	18,774	19,268	19,762	20,256	20,750	21,244	21,738	22,232	22,726	23,220	494
GS-6	20,929	21,480	22,031	22,582	23,133	23,684	24,235	24,786	25,337	25,888	551
GS-7	23,254	23,866	24,478	25,090	25,702	26,314	26,926	27,538	28,150	28,762	612
GS-9	22,458	23,207	23,956	24,705	25,454	26,203	26,952	27,701	28,450	29,199	749

ATTACHMENT B

CIRCLED AMOUNTS INDICATE ENTRY

DIAGNOSTIC RADIOLOGIC TECHNICIAN/TECHNOLOGIST, GS-647

GRADE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	AMOUNT OF STEP INCREASE
GS-5 (10)	$20,463	20,988	21,513	22,038	22,563	23,088	23,613	24,138	24,663	25,188	$525
GS-6 (10)	22,807	23,392	23,977	24,562	25,147	25,732	26,317	26,902	27,487	28,072	585
GS-7 (10)	25,343	25,993	26,643	27,293	27,943	28,593	29,243	29,893	30,543	31,193	650
GS-8 (9)	27,350	28,070	28,790	29,510	30,230	30,950	31,670	32,390	33,110	33,830	720
GS-9 (8)	29,411	30,206	31,001	31,796	32,591	33,386	34,181	34,976	35,771	36,566	795
GS-10 (7)	31,511	32,386	33,261	34,136	35,011	35,886	36,761	37,636	38,511	39,386	875

CIRCLED AMOUNT INDICATES ENTRANCE RATE

RATES ARE ALIGNED TO 1/1/89 PAY SCALE

effective 4/9/89

Veterans
Administration

Memorandum

Date: January 11, 1989

From: Chief, Personnel Service (05)

Subj: Special Salary Rates

To: All Pharmacists

1. The Chief Medical Director, VA Central Office, has approved an increase in the special salary rates for GS-9/11/12/13 Pharmacists. We have provided a copy of the new pay rates on the reverse side of this memorandum.

2. This pay increase was effective January 1, 1989 and should be reflected in your paycheck of January 24, 1989.

Donna J. Cardillo
DONNA J. CARDILLO

VA FORM
SEP 1984 2105

SPECIAL SALARY RATES

EFFECTIVE: 1/1/89

PHARMACIST, GS-660

GRADE		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	Amount of Step Increase
GS-9	(10)	$31,001	31,796	32,591	33,386	34,181	34,976	35,771	36,566	37,361	38,156	$795
GS-11	(10)	37,510	38,472	39,434	40,396	41,358	42,320	43,282	44,244	45,206	46,168	962
GS-12	(7)	41,498	42,651	43,804	44,957	46,110	47,263	48,416	49,569	50,722	51,875	1153
GS-13	(4)	45,234	46,605	47,976	49,347	50,718	52,089	53,460	54,831	56,202	57,573	1371

- RATES CORRESPOND TO 1/1/89 PAY SCALE

- CIRCLED AMOUNT INDICATES ENTRANCE RATE

Effective 1/17/88

PHARMACIST, GS-660

RADE	1	2	3	4	5	6	7	8	9	10	Amount of Step Increase
* GS-9 (10)	29,199	29,948	30,697	31,446	32,195	32,944	33,693	34,442	35,191	35,940	749
** GS-10 (9)	31,324	32,148	32,972	33,796	34,620	35,444	36,268	37,092	37,916	38,740	824
* GS-11 (8)	33,514	34,420	35,326	36,232	37,138	38,044	38,950	39,856	40,762	41,668	906
** GS-12 (4)	35,825	36,911	37,997	39,083	40,169	41,255	42,341	43,427	44,513	45,599	1086

* Increase in special salary rate

** New special salary rate authorized

OTE: Salaries not aligned with 1/3/88 pay scale - aligned to 1/4/87 pay scale

Attachment G.

NEW YORK STATE SALARY SCHEDULE

TITLE	ENDING SALARY	BEGINNING SALARY	GRADE	LOCATION PAY 703
Clerk	$19,268	$15,483	6	
Keyboard Stenographer	19,268	15,483	6	
LPN	25,307	20,547	11	
Nurse I	29,811	24,441	14	
Occupational Therapist	33,210	27,370	16	
Physical Therapist	33,210	27,370	16	
Pharmacist	35,105	28,940	17	
Medical Specialist I	76,676	64,235	35	(Add 10%)
Medical Specialist II	89-90,000	66,290	38	(Add 10%)
Medical Specialist III			38	(Add 10%)
Clinical Physician I	73,099	61,046	34	
Clinical Physician II	80,355	67,788	36	
Physician Assistant	32,801	26,384	18	
Social Worker I	32,801	26,354	18	
Social Worker II	36,553	29,256	20	
Psychologist I	38,138	30,833	21	
Psychologist II	42,185	34,260	23	
Psychiatrist I	76,676	64,235	35	
Psychiatrist II	90,000	66,290	38	
Psychiatrist III	90,000- 2%		38	

ANNUAL SALARY RATES EFFECTIVE 01/01/88
SUFFOLK COUNTY

TITLE	GRADE	SALARY
Clerk	8	$16,234
Clerk Typist	8	16,234
Sr. Clerk	10	17,696
Sr. Clerk Typist	10	17,696
Stenographer	8	16,234
Sr. Stenographer	10	17,696
Secretary	10	17,696
Nurse Aide	7	15,530
Occupational Therapist	17	24,038
Pharmacist	21	28,527
Physical Therapist	21	28,527
Physician I	36	54,445
Physician II	37	56,846
Physician III	38	59,351
Physicians Assistant I	23	31,137
Physicians Assistant II	26	35,392
Psychiatrist I	36	54,445
Psychiatrist II	37	56,846
Psychiatrist III	38	59,351
Public Health Nurse I	19	26,204
Public Health Nurse II	23	31,137
Public Health Nurse III	27	37,010
Public Health Nurse IV	29	40,272
Registered Nurse	17	24.038

ATTAchment G

ANNUAL SALARY RATES EFFECTIVE 1/1/88

GRADE	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(10A)	(11)
2	12,580	13,102	13,703	14,303	14,929	15,530	16,234	17,435	18,53
3	13,102	13,703	14,303	14,929	15,530	16,234	17,017	18,113	19,31
4	13,703	14,303	14,929	15,530	16,234	17,017	17,696	18,896	19,993
5	14,303	14,929	15,530	16,234	17,017	17,696	18,505	19,653	20,802
6	14,929	15,530	16,234	17,017	17,696	18,505	19,392	20,462	21,533
7	15,530	16,234	17,017	17,696	18,505	19,392	20,228	21,324	22,394
8	16,234	17,017	17,696	18,505	19,392	20,228	21,115	22,237	23,386
9	17,017	17,696	18,505	19,392	20,228	21,115	22,055	23,203	24,325
10	17,696	18,505	19,392	20,228	21,115	22,055	22,994	24,247	25,552
11	18,505	19,392	20,228	21,115	22,055	22,994	24,038	24,952	25,891
12	19,392	20,228	21,115	22,055	22,994	24,038	25,082	26,074	27,040
13	20,228	21,115	22,055	22,994	24,038	25,082	26,204	27,248	28,345
14	21,115	22,055	22,994	24,038	25,082	26,204	27,327	28,423	29,571
15	22,055	22,994	24,038	25,082	26,204	27,327	28,527	29,806	31,059
16	22,994	24,038	25,082	26,204	27,327	28,527	29,754	31,163	32,547
17	24,038	25,082	26,204	27,327	28,527	29,754	31,137	32,573	34,008
18	25,082	26,204	27,327	28,527	29,754	31,137	32,468	34,008	35,600
19	26,204	27,327	28,527	29,754	31,137	32,468	33,956	35,600	37,245
20	27,327	28,527	29,754	31,137	32,468	33,956	35,392	37,165	38,993
21	28,527	29,754	31,137	32,468	33,956	35,392	37,010	38,915	40,873
22	29,754	31,137	32,468	33,956	35,392	37,010	38,576	40,559	42,543
23	31,137	32,468	33,956	35,392	37,010	38,576	40,272	42,282	44,266
24	32,468	33,956	35,392	37,010	38,576	40,272	42,047	44,005	46,014
25	33,956	35,392	37,010	38,576	40,272	42,047	43,926	45,936	47,946
26	35,392	37,010	38,576	40,272	42,047	43,926	45,858	47,972	50,060
27	37,010	38,576	40,272	42,047	43,926	45,858	47,894	50,060	52,200
28	38,576	40,272	42,047	43,926	45,858	47,894	49,982	52,174	54,445
29	40,272	42,047	43,926	45,858	47,894	49,982	52,174	54,549	56,846
30	42,047	43,926	45,858	47,894	49,982	52,174	54,445	56,893	59,378
31	43,926	45,858	47,894	49,982	52,174	54,445	56,846	59,430	62,065
32	45,858	47,894	49,982	52,174	54,445	56,846	59,351	62,092	64,805
33	47,894	49,982	52,174	54,445	56,846	59,351	61,961	64,859	67,677
34	49,982	52,174	54,445	56,846	59,351	61,961	64,650	67,625	70,574
35	52,174	54,445	56,846	59,351	61,961	64,650	67,573	70,679	73,811
36	54,445	56,846	59,351	61,961	64,650	67,573	70,496	73,889	77,256
37	56,846	59,351	61,961	64,650	67,573	70,496	73,628	77,230	80,753
38	59,351	61,961	64,650	67,573	70,496	73,628	76,786	80,623	82,920
39	61,961	64,650	67,573	70,496	73,628	76,786	80,258	82,920	82,920
40	64,650	67,573	70,496	73,628	76,786	80,258	82,920	82,920	82,920
41	67,573	70,496	73,628	76,786	80,258	82,920	82,920	82,920	82,92
42	70,496	73,628	76,786	80,258	82,920	82,920	82,920	82,920	82,9
43	73,628	76,786	80,258	82,920	82,920	82,920	82,920	82,920	82,9
44	76,786	80,258	82,920	82,920	82,920	82,920	82,920	82,920	82,9
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					

11 6 11

Veterans Administration

Memorandum

Manhattan
BRonx
BKlyn?

October 14, 1987

Chief, Personnel Service (05)

Special Salary Rates

All Service Chiefs

1. The Office of Personnel Management has authorized the following special salary rates for Clerk-Typists, Clerk-Stenographers, Data Transcribers and all other clerical positions with the parenthetical title (typing) or (stenography) GS-2 through GS-6:

	1	2	3	4	5	6	7	8	9	10	AMT WGI
2	$13,611	13,960	14,309	14,658	15,007	15,356	15,705	16,054	16,403	16,752	$349
3	$14,946	15,339	15,732	16,125	16,518	16,911	17,304	17,697	18,090	18,483	$393
4	$15,900	16,342	16,784	17,226	17,668	18,110	18,552	18,994	19,436	19,878	$442
5	$16,798	17,292	17,786	18,280	18,774	19,268	19,762	20,256	20,750	21,244	$494
6	$17,623	18,174	18,725	19,276	19,827	20,378	20,929	21,480	22,031	22,582	$551

2. The effective date of this adjustment is October 11, 1987. Pay adjustments for employees on the rolls in these categories will be automatically processed by Personnel Service.

3. If you have any questions concerning this matter, please contact Mr. Howard A. Sayes, Chief, Staffing Section, at extension 504.

PHILIP S. DITEODORO

ATTACHMENT H

Suffolk + Nassau

GENERAL SCHEDULE 5 U.S.C. 5332(a)

2087

GS	1	2	3	4	5	6	7	8	9	10	Amt. of Step Incr.
1	$9,811	$10,139	$10,465	$10,791	$11,117	$11,309	$11,631	$11,955	$11,970	$12,275	Varies
2	11,032	11,294	11,659	11,970	12,103	12,459	12,815	13,171	13,527	13,883	Varies
3	12,038	12,439	12,840	13,241	13,642	14,043	14,444	14,845	15,246	15,647	$401
4	13,513	13,963	14,413	14,863	15,313	15,763	16,213	16,663	17,113	17,563	450
5	15,118	15,622	16,126	16,630	17,134	17,638	18,142	18,646	19,150	19,654	504
6	16,851	17,413	17,975	18,537	19,099	19,661	20,223	20,785	21,347	21,909	562
7	18,726	19,350	19,974	20,598	21,222	21,846	22,470	23,094	23,718	24,342	624
8	20,739	21,430	22,121	22,812	23,503	24,194	24,885	25,576	26,267	26,958	691
9	22,907	23,671	24,435	25,199	25,963	26,727	27,491	28,255	29,019	29,783	764
10	25,226	26,067	26,908	27,749	28,590	29,431	30,272	31,113	31,954	32,795	841
11	27,716	28,640	29,564	30,488	31,412	32,336	33,260	34,184	35,108	36,032	924
12	33,218	34,325	35,432	36,539	37,646	38,753	39,860	40,967	42,074	43,181	1107
13	39,501	40,818	42,135	43,452	44,769	46,086	47,403	48,720	50,037	51,354	1317
14	46,679	48,235	49,791	51,347	52,903	54,459	56,015	57,571	59,127	60,683	1556
15	54,907	56,737	58,567	60,397	62,227	64,057	65,887	67,717	69,547	71,377	1830
*16	64,397	66,544	68,691	70,838	72,500	73,660	75,765	77,870	79,975		Varies
*17	73,958	76,423	78,888	81,353	83,818						2465
*18	86,682										

General Schedule Effective January 3, 1988
Office of Personnel and Labor Relations
Veterans Administration

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*The rate of basic pay payable to employees at these rates is limited to $72,500, the rate payable for level V of the Executive Schedule.

ι Brief . . .

☐ Weather Service Testing Ban — Federal Judge bert Schnacke in San Francisco has issued a preliminy injunction barring drug testing of National Weather rvice Employees Organization members while he coners a suit against the legality of the planned testing of ather forecasters.

☐ Employment Agencies Welcome — In an August 23 *deral Register* notice, the Office of Personnel Management authorized agencies to pay private employment rvices to help in hiring for hard-to-fill positions such as gineering and medical services.

☐ Closed Caption TV — Sen. Tom Harkin, D-Iowa, has introduced a bill (S-2704) that would prohibit reimbursing federal employees on official travel who stay in hotels that don't provide upon request guest rooms furnished with televisions that have closed captioning for the hearing impaired. A bill has passed the House that would require federal travelers to stay in hotels equipped with water sprinklers.

☐ Travel Expense Waste — A House Government Operations Committee report says that better auditing of the $4 billion spent annually on official travel expenses could save the government millions of dollars each year. The committee estimates that up to 10 percent of transportation bills are inflated. About $58 million in overcharges recovered last year.

JANUARY 1989 GENERAL SCHEDULE PAY CHART*

	1	2	3	4	5	6	7	8	9	10
GS-1	$10,213	$10,555	$10,894	$11,233	$11,573	$11,773	$12,108	$12,445	$12,461	$12,780
2	11,484	11,757	12,137	12,461	12,601	12,972	13,343	13,714	14,085	14,456
3	12,531	12,949	13,367	13,785	14,203	14,621	15,039	15,457	15,875	16,293
4	14,067	14,536	15,005	15,474	15,943	16,412	16,881	17,350	17,819	18,288
5	15,738	16,263	16,788	17,313	17,838	18,363	18,888	19,413	19,938	20,463
6	17,542	18,127	18,712	19,297	19,882	20,467	21,052	21,637	22,222	22,807
7	19,493	20,143	20,793	21,443	22,093	22,743	23,393	24,043	24,693	25,343
8	21,590	22,310	23,030	23,750	24,470	25,190	25,910	26,630	27,350	28,070
9	23,846	24,641	25,436	26,231	27,026	27,821	28,616	29,411	30,206	31,001
10	26,261	27,136	28,011	28,886	29,761	30,636	31,511	32,386	33,261	34,136
11	28,852	29,814	30,776	31,738	32,700	33,662	34,624	35,586	36,548	37,510
12	34,580	35,733	36,886	38,039	39,192	40,345	41,498	42,651	43,804	44,957
13	41,121	42,492	43,863	45,234	46,605	47,976	49,347	50,718	52,089	53,460
14	48,592	50,212	51,832	53,452	55,072	56,692	58,312	59,932	61,552	63,172
15	57,158	59,063	60,968	62,873	64,778	66,683	68,588	70,493	72,398	74,303
16	67,038	69,273	71,508	73,743	75,473	76,678*	78,869*	81,060*	82,500*	
17	76,990*	79,556*	82,122*	82,500*	83,818*					
18	86,682*									

*Reflects a 4.1 percent increase across the board. The rate of basic pay payable to employees at these rates is limited to the rate for level V of the Executive Schedule, which will be $75,500.

• DON MACE, Editor • ERIC YODER, Assistant Editor • JOSEPH YOUNG, Publisher •

(The Comptroller General has ruled that federal departments and agencies may purchase subscriptions to the Federal Employees' News Digest with government funds. The decision is No. B-185591, issued May 5, 1976.)

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EEKLY
EDERAL
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EWS
IGEST

GS1 file clerk
GS3- " "
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GS5- [illegible]
[illegible] with experience

WEEKLY FEDERAL EMPLOYEES' NEWS DIGEST (ISSN: 0430-1692) is published weekly except the last week in December and the first week in January at 510 N. Washington St., Falls Church, Virginia 22046. Second Class postage paid at Falls Church, VA and additional mailing offices. POSTMASTER: Send address changes to WEEKLY FEDERAL EMPLOYEES' NEWS DIGEST, P.O. Box 7528, Falls Church, VA 22046-1428.
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2nd Class Express Delivery

VETERANS ADMINISTRATION
WASHINGTON, D. C.

ISSUE DATE - MAY 5 1988

REGULAR AND SPECIAL PRODUCTION FACILITATING WAGE RATE SCHEDULES -- FEDERAL WAGE SYSTEM
WAGE AREA - NEW YORK, NEW YORK (094)
EFFECTIVE DATE IN VA - JULY 3, 1988

P.D. #14

THE FOLLOWING REGULAR AND SPECIAL SCHEDULES ARE ESTABLISHED UNDER 5 U.S.C. 5343(A) FOR FEDERAL WAGE SYSTEM EMPLOYEES AT INSTALLATIONS SHOWN BELOW, PURSUANT TO WAGE SURVEY ORDERED JANUARY 19, 1988. THEY ARE TO BE APPLIED IN ACCORDANCE WITH THE PROVISIONS OF FPM SUPPLEMENT 532-1. PURSUANT TO PL 100-202, AMOUNTS OF INCREASES HAVE BEEN RESTRICTED TO 2 PERCENT AND THE EFFECTIVE DATE HAS BEEN DELAYED FROM MARCH 27, 1988.

SUPERSEDES SCHEDULE ISSUED MAY 6, 1987.

WG,WL GRADE	WG STEP RATES 1	2	3	4	5	WL STEP RATES 1	2	3	4	5
1	7.55	7.87	8.20	8.52	8.84	8.31	8.65	9.01	9.36	9.72
2	8.07	8.41	8.76	9.07	9.42	8.88	9.25	9.63	10.00	10.37
3	8.51	8.88	9.22	9.56	9.92	9.36	9.76	10.13	10.54	10.93
4	8.93	9.32	9.69	10.06	10.42	9.84	10.26	10.65	11.07	11.47
5	9.35	9.75	10.12	10.52	10.92	10.30	10.71	11.14	11.59	12.00
6	9.79	10.20	10.61	11.02	11.42	10.77	11.23	11.67	12.12	12.57
7	10.21	10.64	11.07	11.49	11.93	11.25	11.70	12.18	12.65	13.12
8	10.63	11.07	11.51	11.96	12.40	11.69	12.19	12.68	13.16	13.67
9	11.06	11.53	11.99	12.46	12.92	12.18	12.68	13.18	13.71	14.21
10	11.50	11.98	12.47	12.94	13.43	12.64	13.16	13.70	14.22	14.76
11	11.93	12.43	12.91	13.42	13.91	13.13	13.68	14.21	14.77	15.32
12	12.35	12.86	13.39	13.90	14.43	13.57	14.15	14.72	15.28	15.85
13	12.78	13.31	13.85	14.39	14.91	14.05	14.64	15.23	15.82	16.41
14	13.18	13.74	14.30	14.84	15.41	14.53	15.14	15.73	16.34	16.97
15	13.62	14.19	14.76	15.33	15.91	15.00	15.62	16.25	16.88	17.49

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WS GRADE	WS, WD, WN STEP RATES 1	2	3	4	5	PAY LEVELS WD	WN
1	11.10	11.59	12.05	12.50	12.97		
2	11.56	12.03	12.51	13.00	13.47		
3	11.96	12.47	12.97	13.46	13.97	1	
4	12.39	12.91	13.43	13.94	14.47	2	
5	12.82	13.36	13.88	14.43	14.94	3	
6	13.23	13.80	14.36	14.91	15.46	4	
7	13.69	14.24	14.82	15.41	15.97	5	1
8	14.10	14.70	15.28	15.88	16.47	6	2
9	14.53	15.14	15.73	16.34	16.97	7	3
10	14.95	15.59	16.22	16.84	17.46	8	4
11	15.36	16.00	16.64	17.28	17.93	9	5
12	15.88	16.54	17.20	17.87	18.52	10	6
13	16.52	17.21	17.91	18.59	19.28	11	7
14	17.28	18.01	18.73	19.45	20.17		8
15	18.16	18.93	19.68	20.44	21.19		9
16	19.16	19.97	20.76	21.56	22.35		
17	20.28	21.13	21.97	22.82	23.66		
18	21.54	22.44	23.32	24.23	25.12		
19	22.89	23.86	24.80	25.76	26.72		

INSTALLATIONS FOR WHICH ABOVE SCHEDULES ARE AUTHORIZED*

(SEE REVERSE SIDE)

John A Gronvall, M.D.

JOHN A. GRONVALL, M. D.
CHIEF MEDICAL DIRECTOR

FEDERAL EMPLOYMENT PROCESSES

Prepared for

THE NATIONAL VETERANS TRAINING INSTITUTE

By

THE DENVER REGION
U.S. OFFICE OF PERSONNEL MANAGEMENT

OVERVIEW AND PURPOSE

The purpose of this handout is to provide state employment service representatives with a better understanding of how Federal jobs are filled so that they can improve service to their clients.

The handout will focus on seven main points:

- The "conventional wisdom" about how most Federal jobs are filled
- Hiring patterns in Federal employment
- How to approach the Federal job market
- The role of the Office of Personnel Management
- The role of other Federal agencies
- Veterans' preference in Federal employment
- Special appointment authorities for veterans

THE "CONVENTIONAL WISDOM"

How do most people get appointed to jobs with the Federal Government? If you answer that most people get Federal jobs by applying to the Office of Personnel Management (OPM), taking an OPM test, getting on an OPM register, and being selected from an OPM certificate by an agency, you are not alone in your view. Many of us tend to think of the Government's recruiting and selection practices in terms of this conventional view--a view in which the OPM and its competitive examining operations have key roles in filling most Federal jobs. The facts, however, do not support this conventional wisdom.

Each year, the vast majority of appointments in the Federal Service are made through agency controlled hiring systems in which OPM plays no direct role. Chart 1 on the next page displays this fact using the most recent available nationwide data (Fiscal Year 1984).

ATTACHMENT I

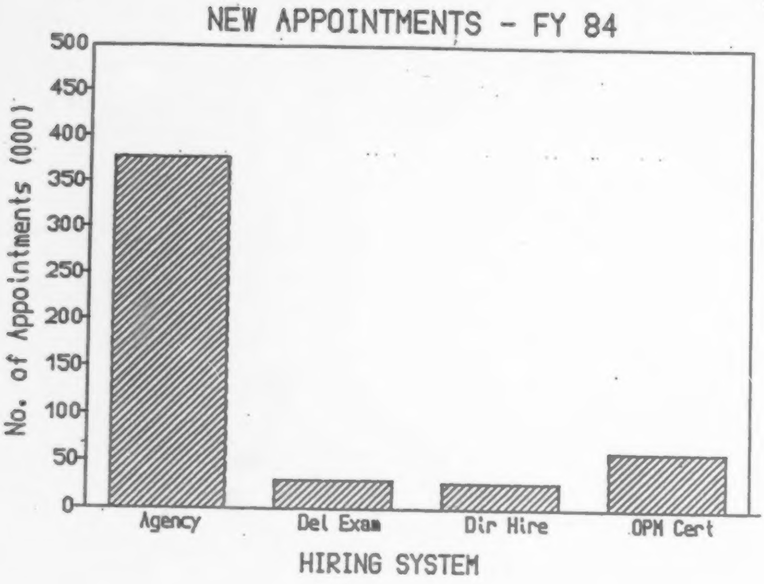

Chart 1

In FY84 the overwhelming majority of new appointments, well over 75%, were made through agency hiring systems without any involvement of OPM. Another 11% were made directly by agencies either through delegated examining agreements or direct hire authorities issued to agencies by OPM. Appointments made from OPM certificates accounted for only about 12% of all new appointments made in 1984.

The fallacy, and danger, of the "conventional wisdom" is obvious from the above data. If job seekers limit their contacts to OPM, their chances of getting a Federal job are greatly reduced. Since more than three-quarters of new appointments are made through individual Federal agency hiring systems and another 11% of new appointments are made directly by agencies through some type of delegated authority from OPM, job seekers who only apply through OPM are restricting their opportunities to get a Federal job to just 10 to 15% of the potential market. Put another way, such job seekers are cutting themselves off from over 85% of the available Federal jobs.

FEDERAL HIRING PATTERNS

In order to be effective in the Federal job market, it is important to understand the general nature of the market and how jobs are filled within that market. This section describes the Federal Government's actual hiring patterns for a typical fiscal year (1984). It examines the nature of all new appointments made and explains in general the kinds of hiring systems used. (The table in the Appendix summarizes the Central Personnel Data File new appointment data on which the information in this section is based.)

New hires in the Federal Government are about evenly split between the excepted and the competitive services. As reflected in Chart 2, about 48% of all new appointments in FY 1984 were to positions in the Excepted Service and about 52% to positions in the competitive service.

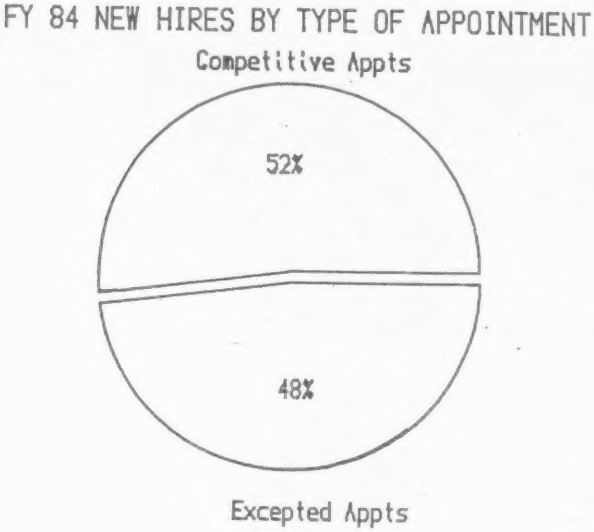

Chart 2

Excepted Service Appointments

The Excepted Service consists of those civil service positions in the executive branch of the Federal Government which are specifically excepted from the competitive service by statute, the President, or the Office of Personnel Management. Each agency prescribes its own requirements for appointments in the Excepted Service. Excepted Service appointments do not confer competitive "status"; but, depending on the situation, may entitle a person to certain fringe benefits, including Federal retirement.

In 1984 over 238,000 new Excepted Service appointments were made. While the majority of these appointments were time limited (about 70-75%), the rest were made without time limit and some could continue for as long as an individual's entire working career.

There are numerous excepted appointing authorities. However, as far as the job applicant is concerned, they all share one important characteristic. Excepted appointments are made directly by agencies through selection process operated and controlled by them. In order to apply and be considered for Excepted Service positions, job applicants must deal directly with the individual agencies doing the hiring.

Competitive Service Appointments

Slightly over a quarter million new competitive service appointments were made in 1984. Of these, as shown in Chart 3, roughly 55% were temporary and 45% were permanent (career or career-conditional).

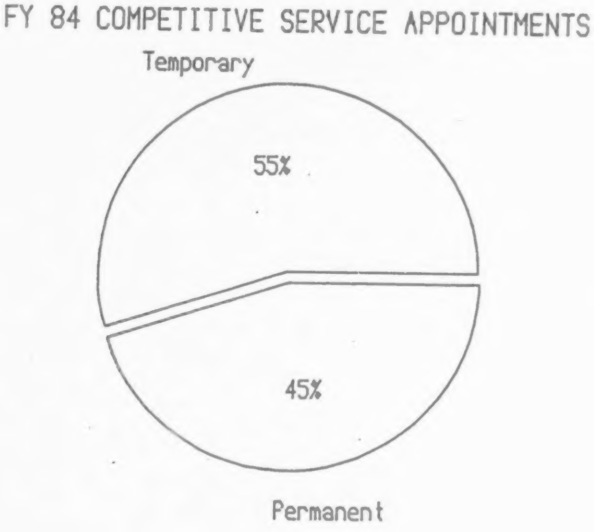

Chart 3

Temporary Competitive Appointments

Temporary appointments are for one of three primary types of employment:

- Temporary Appointment Pending Establishment of a Register (TAPER) employment;

- Term employment of a project nature lasting from one to four years; and

- Temporary limited employment for a specified period not to exceed a year.

Of the three, temporary limited employment is by far the most common and accounts for most of the temporary appointments made by agencies. In FY84 agencies had delegated authority from OPM to make such appointments to all General Schedule (GS) and similar positions at GS-7 and below and to all Federal Wage System positions. This and other delegations account for the fact, as reflected in Chart 4, that almost 95% of all temporary competitive appointments in FY 84 were made directly by agencies under some type of delegated authority.

In January of 1985 OPM increased agency authorities in this area even further by allowing agencies to make temporary limited appointments to all GS and similar positions at GS-12 and below, and by allowing agencies to extend temporary limited appointments in one year increments up to four years.

FY 84 TEMPORARY COMPETITIVE APPOINTMENTS

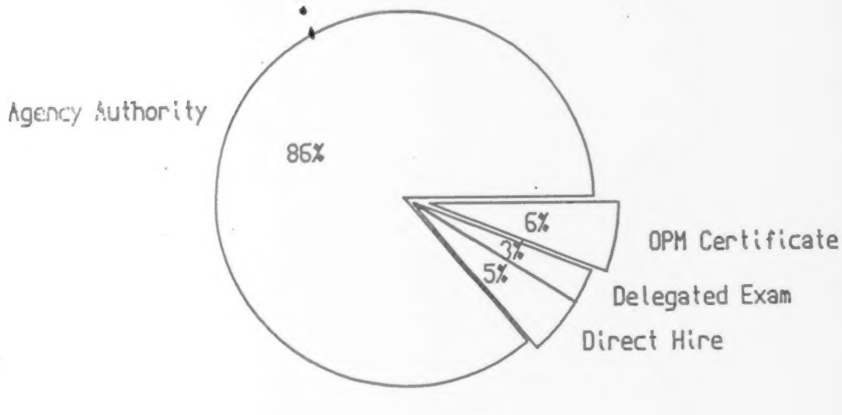

Chart 4

When it comes to temporary competitive appointments, the conventional wisdom about the key role of OPM in filling jobs is totally inaccurate. As clearly displayed in the above chart, OPM plays a very minor role in filling temporary jobs in the competitive service. Almost all such jobs are filled directly by agencies through various authorities delegated to them.

This fact, combined with the fact that over 55% of all competitive service jobs are temporary in nature, is of critical importance to those seeking Federal employment. If job applicants restrict themselves to dealing with OPM and getting on OPM registers, they effectively cut themselves off from the very large (and growing) Federal job market of temporary employment. To take advantage of this market, applicants must contact and deal directly with the agencies that have the temporary jobs.

Permanent Competitive Appointments

Even when it comes to permanent competitive appointments, the conventional wisdom is on shaky ground. As reflected in the Chart 5, only 45% of the new career/career conditional appointments in FY 1984 were made from OPM registers.

Agencies made about 55% of the career/career conditional appointments in FY 84 directly through authorities delegated to them. Of these, 22% were through delegated examining, 16% through various direct hire authorities, and the remaining 17% through agency authorities to convert non-competitively certain excepted appointments, such as cooperative education appointments and Veterans Readjustment Appointments (VRAs). Thus, even when seeking permanent civil service jobs, applicants who restrict their job hunting to jobs filled through OPM registers are severely limiting their potential opportunities.

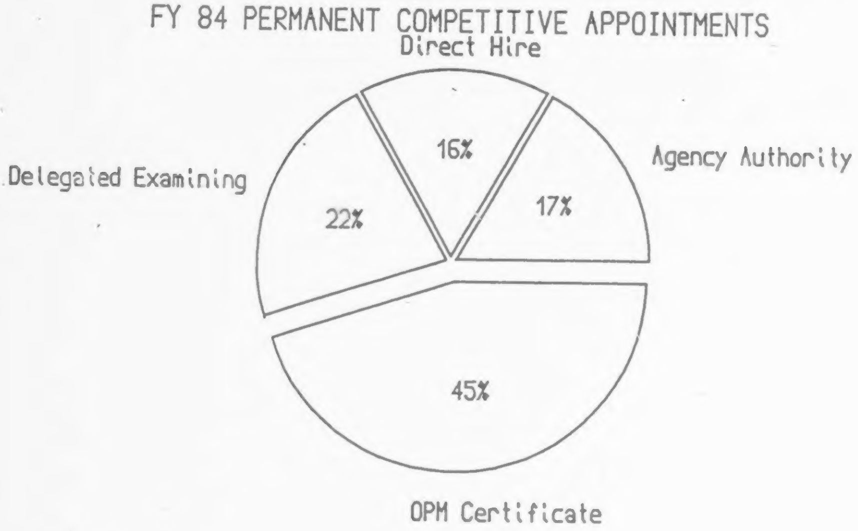

Chart 5

HOW TO APPROACH THE FEDERAL JOB MARKET

Apply to a variety of Federal Employers

The above information on hiring patterns in the Federal Government clearly demonstrates that the Federal job market is not comprised of a single employer with a single employment system. Rather, it is a market made up of multiple employers and a variety of employment systems. The Federal job market must be approached with this important reality in mind.

Serious job seekers in the private sector do not limit their search to one company. Instead, they contact a wide variety of potential employers for whom they might like to work. Serious job seekers in the Federal sector should follow the same technique.

Each Federal agency and its component offices are individual employers. These individual employers, on the average, fill most of their jobs through employment systems that involve direct application to them. An effective approach to the Federal job market, therefore, relies on application to a number of different agencies, only one of which is the Office of Personnel Management.

Be available for a variety of different jobs

If a job applicant insists on a permanent (career-conditional) job, this is certainly his or her prerogative. However, in doing so the applicant restricts the job market to less than 25% of the potential opportunities. If the applicant insists further on a permanent job that is full-time, the available opportunities shrink even further.

As with job-hunting in the private sector, the less rigid applicants are in the types of jobs they will consider, the broader the potential job market. For example, if Federal job seekers are willing to accept temporary as well as career-conditional competitive appointments, they increase their potential job market by almost 120%. If applicants further broaden their availability to include jobs in the Excepted Service, the potential job market is increased by roughly an additional 100%.

Another important reasons exists for job applicants to consider jobs other than just permanent career/career-conditional ones. Many of the people who initially take temporary or excepted appointments eventually get appointed to career or career-conditional positions without a break in service. Some of these "conversions" take place noncompetitively based on the nature of the initial appointment, e.g. VRAs, cooperative education excepted appointments, and appointment of 30% disabled veterans to temporary positions. Others take place when an individual already working for an agency in some capacity is selected for a permanent appointment from a civil service register. While these selections must follow merit selection procedures, the fact that a candidate is already working for the agency and his or her performance is a known quantity can have influence on the final employment decision.

As displayed in Chart 6, about one-third of all new career/career-conditional appointments made nationwide in FY 84 were of people already working for the Government under some other type of appointment:

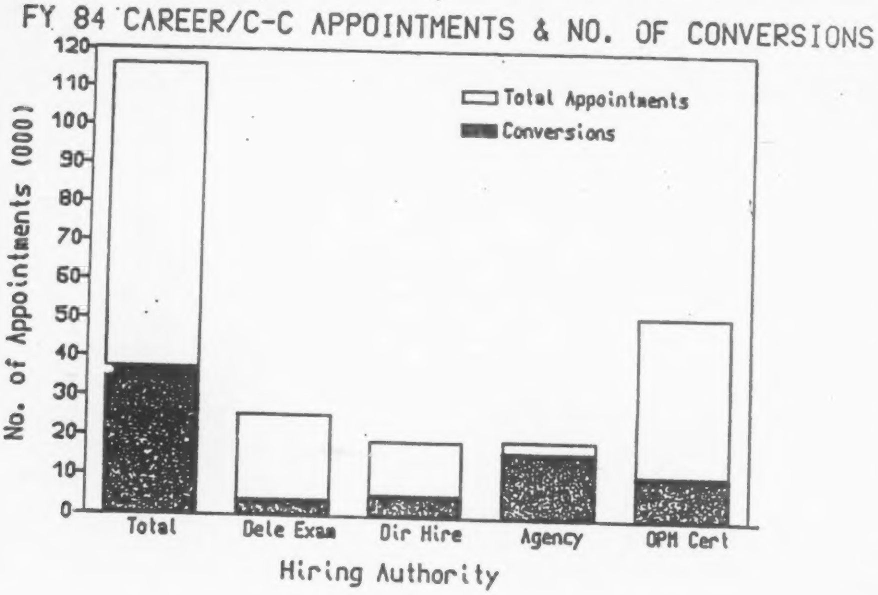

Chart 6

Find out what jobs agencies are recruiting for

For Excepted Service positions, including cooperative education and VRA opportunities, the only sure fire way to find out what jobs agencies are recruiting for is to contact individual agencies and ask. Although some agencies may place a job order with a state employment service facility, this is not a general requirement.

For competitive service jobs, there are three sources of job information. The first is the state employment service office or offices in the publicity area. Publicity about recruitment for both permanent and temporary competitive service job opportunities, whether announced by OPM or individual agencies, must be provided to appropriate state employment offices. OPM's Job Information Centers (JICs) are a second source of information about competitive service job opportunities. These offices provide information on nationwide, regional, and local vacancies for which OPM is recruiting. JICs also post opportunities announced by other agencies under delegated examining authorities, and typically include nationwide delegated examining announcements in their printed Federal Job Opportunities Lists. Employing agencies are the third source of information about competitive civil service jobs. Local agency personnel offices maintain information on all the vacancies for which they are recruiting.

All jobs announced through OPM's Federal Job Opportunities Lists are open to the general public. However, some jobs announced by agencies are open only to current Federal employees or applicants with "status". Status applicants are former Federal employees who may be reinstated non-competitively to the position based upon their past civilian Government service.

Obtain the necessary application forms

Just as there is no single Federal employer or source of Federal job information, there is no single, all-purpose application form for Federal employment. Because of the plurality of employing agencies, job requirements, and examining systems, a wide variety of application forms are used.

Although the Standard Form 171 - Application for Federal Employment is used for many jobs, it is not used for all and is frequently only one part of a total application package.

The correct and complete application package for any vacancy can be obtained from the office issuing the announcement.

Submit forms by closing date

Individual recruiting announcements contain instructions on where to submit completed application forms. Most announcements also have a closing date for the receipt of applications. Completed applications must be received or, in some cases, postmarked by this date. Applications which do not meet the closing date requirements of the particular announcement will not be accepted.

THE ROLE OF THE OFFICE OF PERSONNEL MANAGEMENT

The Office of Personnel Management plays a significant, but limited role in Federal employment processes.

Policy-making role

As the central personnel agency for the Federal Government, OPM is responsible for establishing Governmentwide regulations and policies affecting recruitment and selection in the competitive service. The trend of the last few years has been to simplify OPM requirements and to allow agencies as much authority as possible to manage their own affairs.

Operational role

The purpose of OPM's examining network is to assist agencies in filling their jobs with high quality candidates selected on merit. Through its area office network, OPM continues to recruit, examine, and certify for about 45% of the permanent competitive service vacancies filled by Federal agencies each year. Based on agency requests, OPM notifies the public about these job opportunities through its own information centers and through state employment service offices. OPM examining offices accept and rate applications from the general public; and refer lists of eligibles in score order to other Federal agencies to fill their career-conditional jobs. In some very infrequent instances, agencies also may request OPM assistance in filling temporary jobs.

Oversight role

The Office of Personnel Management has delegated significant authorities to agencies to do their own recruiting and examining for competitive service positions. In some cases, this takes the form of Governmentwide delegations to all agencies, such as the authority to make and extend temporary appointments. In other cases, the delegation may be specific to an occupation, such as the worldwide direct hire authority for most types of engineers. In still other cases, the delegation may be to a specific agency to examine for one or more specific occupations in specific locations.

Regardless of the type or scope of the delegation, OPM has a responsibility to oversee and monitor the exercise of authorities it has delegated to agencies. When OPM discovers substantive abuses of its regulations or merit system principles, it can and does order agencies to take corrective action.

OPM's oversight role, however, does not generally extend to dealing with complaints against agencies from individual applicants. Such complaints should be directed to the agency involved or to the Special Counsel of the Merit System Protection Board if the applicant alleges that a prohibited personnel practice was committed.

THE ROLE OF OTHER FEDERAL AGENCIES

Individual Federal agencies play a crucial role in the Federal employment process. They have the jobs. They decide whether the jobs will be permanent or temporary, full-time or part-time, seasonal or continuing. They fill the vast majority of their jobs through hiring systems they manage and control. And, regardless of the hiring system used, they make the final employment decisions.

VETERANS' PREFERENCE IN FEDERAL EMPLOYMENT

There are two classes of veterans' preference in Federal employment.

Five-point preference

Five-point preference is given to honorably separated veterans who served on active duty in the armed forces of the United States:

- During any war (the official dates for war service are April 6, 1917 to July 2, 1921, and December 7, 1941 to April 28, 1952);
- In a campaign or expedition for which a campaign badge has been authorized (including the Lebanon and Grenada Operations), and if the person enlisted after September 7, 1980, served continuously for 24 months or the full period called or ordered for active duty. (Individuals who have incurred a disability in the line of duty which the Veterans Administration determines is compensable are excluded form this 24 month requirement.);
- During the period April 28, 1952, through July 1, 1955; or
- For more than 180 consecutive days, any part of which occurred after January 21, 1955, and before October 15, 1976. (An initial period of active duty for training under the "6-month" Reserve or National Guard programs does not count.)

Note: Under Public Law 95-454, (Civil Service Reform Act, October 13, 1978), retired members of the armed forces are no longer considered preference eligibles as of October 1, 1980, unless they are disabled veterans or retired below the rank of major or equivalent.

Ten-point preference

Ten point preference is given to:

- Disabled veterans - An honorably separated veteran who served on active duty in the armed forces at any time, and who (1) has a service-connected disability or (2) is receiving compensation, disability retirement benefits, or pension under laws administered by the Veterans Administration, Army, Navy, Air Force, Coast Guard, or Marine Corps is entitled to 10-point preference. A veteran who has been awarded the Purple Heart for wounds received in action is considered to have a service-connected disability.

- Wives or husbands of disabled veterans - The spouse of a 10-point veteran who, because of a service-connected disability, has been unable to qualify for any appointment in the Federal civil service or in the Government of the District of Columbia is entitled to 10-point preference.

- Widows or widowers of veterans - The unremarried spouse of an honorably separated veteran who served on active duty during any war, or during the period April 28, 1952, through July 1, 1955, or in any service or expedition for which a campaign badge or service medal was authorized, is entitled to 10-point preference. This includes the widow or widower of a veteran meeting any of these service requirements and who died while in the armed forces, unless the circumstances surrounding the death would have been cause for other than honorable separation from the service.

- Mothers of veterans - The mother of a veteran who died under honorable conditions while on active duty in a war or in a campaign or expedition for which a campaign badge or service medal has been authorized, or during the period April 28, 1952, through July 1, 1955, or who became permanently and totally disabled because of a service-connected disability, is entitled to 10-point preference provided that she is widowed, divorced, or separated from the father of the veteran, or the father is permanently and totally disabled. An otherwise eligible mother who has remarried may be granted preference only if, with reference to subsequent marriage, her husband is permanently and totally disabled, or she is divorced or legally separated, or she has been widowed.

How preference applies to ratings

Persons who meet the criteria for veterans' preference and make passing scores on civil service examinations have 5 or 10 points added to the numerical rating they make in open, competitive examinations for appointment to jobs in the competitive Federal service.

How preference applies in the ordering of names on a register

The extra points cause the names of veterans' preference eligibles to stand higher on lists of persons eligible for appointment. Consequently, veterans' preference eligibles (also referred to as preference eligibles), receive earlier consideration for appointment than they otherwise would.

For scientific and professional positions in grades GS-9 and higher, names of eligibles are listed on civil service registers in the order of ratings, as augmented by veterans' preference, if any.

For all other positions, the names of 10-point preference eligibles who have a compensable service-connected disability of 10 percent or more are placed ahead of the names of all other eligibles on a given register. The names of other 10-point eligibles, 5-point eligibles, and nonveterans are listed in order of their numerical ratings, as augmented by veterans' preference, if any.

How preference applies in making selections from competitive registers

By law, selections from competitive civil service registers must be made from among the top three available candidates. When the selecting official is furnished with a list of eligibles (also called a certificate), he or she may select any of the top three available candidates. However, the official may not pass over a preference eligible and appoint a nonpreference eligible lower on the list unless the reasons for passing over the veteran are sufficient and sustained by the examining office with jurisdiction.

How preference applies in making selections outside competitive registers

Veterans' preference applies to appointments made to competitive service positions through individual agency hiring systems. Such systems are used to fill many temporary jobs and are commonly referred to as "outside the register" procedures. Under these procedures persons are considered for appointment in the following priority groups:

(1) Qualified persons entitled to 10-point preference who have a compensable service-connected disability of 10 percent or more (except for professional and scientific positions in grades GS-9 and above).

(2) All other qualified persons entitled to 10-point preference and 5-point preference.

(3) All other qualified applicants.

Appointing officers may select any applicant in the highest group. They may not select from a lower group as long as three fully qualified applicants in a higher group (or in a combination of higher groups) are still available. Thus, if three persons are available in group (1), the appointing officer may not appoint a person from a lower group; if three preference eligibles are available (either 10-point or 5-point), the official may not appoint a nonpreference eligible.

When fewer than three preference eligibles are available, nonpreference eligibles may be tentatively selected. However, before a nonpreference eligible may be appointed, the agency must submit reasons for passing over any preference eligible to the OPM office with jurisdiction and the OPM office must find the reasons for passing over the preference eligible sufficient.

How preference applies in excepted appointments

Veterans' preference also applies to positions in the Excepted Service. However, just as each agency prescribes its own requirements for Excepted Service appointment processes, it also determines the procedures that will be used to ensure that the legal requirements on preference are applied to Excepted Service selections.

SPECIAL APPOINTMENT AUTHORITIES FOR VETERANS

Veterans Readjustment Appointment (VRA)

A Veterans Readjustment Appointment is a means by which Federal agencies can noncompetitively hire qualified veterans of the Vietnam era for full-time, part-time, or intermittent positions at grades 1 through 9. Veterans who complete two years of satisfactory service under this program will be converted to a career or career-conditional appointment. Under present law Veterans Readjustment Appointments may be made through December 31, 1989.

To be eligible a veteran must meet all of the following criteria:

1. The veteran must have served on active duty for a period of more than 180 days, at least 1 day of which was during the Vietnam era (i.e., the period beginning August 5, 1964, and ending May 7, 1975) and must have received other than a dishonorable discharge. A person who has been discharged or released from active duty for a service-connected disability is not required to have served 180 days but must have served at least 1 day during the Vietnam era.

   Active duty means full-time duty in the armed forces other than active duty for training. Most Reserve and National Guard programs do not provide qualifying service.

2. The veteran must be a United States citizen.

3. The veteran must not have completed more than 14 years of education. This requirement does not apply to compensable disabled veterans or to veterans discharged because of service-connected disabilities.

4. The veteran must agree in writing to participate in a training or educational program that has been developed jointly by the veteran and the agency and is both meaningful to the veteran and consistent with the needs of the agency.

For jobs at grades 4 through 9, the veteran need only meet the minimum requirement for the job and the agency may waive the requirement for a written test if it chooses to do so. For grades 1 through 3, military service is enough to meet minimum qualification requirements, if the agency determines the veteran is able to do the work.

Veterans readjustment appointments are made directly by agencies and applicants should contact individual agencies to determine what VRA opportunities exist.

Noncompetitive appointments for 30% or more compensable disabled veterans

Veterans who have a service-connected disability of 30% or more may apply directly to Federal agencies for consideration for noncompetitive temporary appointments. A 30% disabled veteran serving under a temporary appointment which is not limited to 60 days or less may, at the option of the agency, be converted noncompetitively to a career or career-conditional appointment.

NEW APPO. ENTS[1]
BY PAY PLAN, TENURE, AND LEGAL AUTHORITY
NATIONWIDE FY84 CPDF

	PERMANENT / NO TIME LIMIT (TENURE GROUPS 1 AND 2)			TEMPORARY / TIME LIMITED (TENURE GROUPS 0 AND 3)			TOTAL		
	GS[2]	WG[3]	TOTAL	GS[2]	WG[3]	TOTAL	GS[2]	WG[3]	TOTAL
COMPETITIVE APPOINTMENTS - TOTAL	97,569	18,248	115,817	96,725	42,225	138,950	194,294	60,473	254,767
(CONVERSIONS)	(28,076)	(9,143)	(37,219)	(15,253)	(5,275)	(20,528)	(43,329)	(14,418)	(57,747)
FROM OPM CERTIFICATES	44,756	6,915	51,671	7,637	455	8,092	52,393	7,370	59,763
(CONVERSIONS)	(9,406)	(1,692)	(11,098)	(1,192)	(63)	(1,255)	(10,598)	(1,755)	(12,353)
FROM DELEGATED EXAMINING	21,043	4,640	25,683	1,659	2,119	3,778	22,702	6,759	29,461
(CONVERSIONS)	(2,774)	(1,285)	(4,059)	(167)	(378)	(545)	(2,941)	(1,663)	(4,604)
FROM DIRECT HIRE	18,697	240	18,937	7,278	624	7,902	25,975	864	26,839
(CONVERSIONS)	(5,329)	(74)	(5,403)	(1,666)	(110)	(1,776)	(6,995)	(184)	(7,179)
FROM OTHER SOURCES	13,073	6,453	19,526	80,151	39,027	119,178	93,224	45,480	138,704
(CONVERSIONS)	(10,567)	(6,092)	(16,659)	(12,228)	(4,724)	(16,952)	(22,795)	(10,816)	(33,611)
EXCEPTED APPOINTMENTS - TOTAL	44,861	14,296	59,157	145,573	14,512	160,085	207,039[4]	31,657[4]	238,696[4]
ALL NEW APPOINTMENTS - TOTAL	142,430	32,544	174,974	242,298	56,737	299,035	401,333	92,130	493,463

[1] Does not include reinstatements or transfers.
[2] Includes GS, GG, GW, GM, GH, SES and all other white collar pay plans.
[3] Includes WG, WL, WS and all other blue collar pay plans.
[4] These totals are CPDF summaries of all GS and WG excepted appointments which are greater than totals arrived at by adding tenure group data.

EMPLOYMENT OF VETERANS BY OPM REGION
TOTAL NON-POSTAL FEDERAL EMPLOYEES
ON-BOARD AS OF MARCH 31, 1986

	Total Employment	5 Point Preference	10 Point Compensable Disability	10 Point 30% Disabled	10 Point Other Preference	Vietnam Era Veterans	Veterans Readjustment Appointments	Noncompetitive Appointments-30% Disabled
TOTAL	2,045,341	623,632	66,624	24,863	14,157	413,890	43,136	934
% of Total	100.0%	30.5%	3.3%	1.2%	0.7%	20.2%	2.1%	0.0%
ATLANTA	309,113	101,528	12,657	5,186	2,566	73,224	8,390	205
%	15.1%	16.3%	19.0%	20.9%	18.1%	17.7%	19.5%	21.9%
BOSTON	73,440	20,691	2,702	998	395	13,348	1,049	14
%	3.6%	3.3%	4.1%	4.0%	2.8%	3.2%	2.4%	1.5%
CHICAGO	204,449	58,475	5,324	2,026	1,530	37,258	4,031	81
%	10.0%	9.4%	8.0%	8.1%	10.8%	9.0%	9.3%	8.7%
DALLAS	228,496	75,373	10,234	4,422	1,884	54,343	5,787	147
%	11.2%	12.1%	15.4%	17.8%	13.3%	13.1%	13.4%	15.7%
DENVER	100,265	32,208	3,525	1,376	690	21,593	1,847	71
%	5.0%	5.2%	5.3%	5.5%	4.9%	5.2%	4.3%	7.6%
NEW YORK	128,430	34,236	3,722	1,166	781	19,768	2,229	36
%	6.3%	5.5%	5.6%	4.7%	5.5%	4.8%	5.2%	3.9%
PHILADELPHIA	[illegible]	72,293	6,946	2,592	1,760	49,163	6,207	89
%	11.4%	11.6%	10.4%	10.4%	12.4%	11.9%	14.4%	9.5%
ST. LOUIS	86,133	23,436	2,151	819	760	15,265	1,388	42
%	4.2%	3.8%	3.2%	3.3%	5.4%	3.7%	3.2%	4.5%
SAN FRANCISCO	294,200	105,537	11,338	3,685	1,955	74,903	8,598	152
%	14.4%	16.9%	17.0%	14.8%	13.8%	18.1%	19.9%	16.3%
SEATTLE	92,602	33,405	3,044	1,206	481	23,658	2,273	60
%	4.5%	5.4%	4.6%	4.9%	3.4%	5.7%	5.3%	6.4%
WASHINGTON, D.C.	291,980	66,450	4,981	1,387	1,355	31,367	1,337	37
%	14.3%	10.7%	7.5%	5.6%	9.6%	7.6%	3.1%	4.0%

OFFICE OF PERSONNEL MANAGEMENT
REGIONAL OFFICES
STAFFING SERVICES DIVISIONS

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Atlanta, GA 30303
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FTS : 242-3455

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Alabama
Florida
Mississippi
North Carolina
Tennessee
South Carolina
Virginia

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FTS : 454-9764

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Idaho
Nevada
Oregon
Washington

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FTS : 353-2930

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Indiana
Iowa
Kansas
Kentucky
Michigan
Minnesota
Missouri
Nebraska
North Dakota
Ohio
South Dakota
West Virginia
Wisconsin

Philadelphia Region
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Philadelphia, PA. 19106
Comm: 215-597-4431
FTS : 597-4431

Pennsylvania
Connecticut
Delaware
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Puerto Rico
Rhode Island
Vermont
Virgin Islands

Dallas Region
1100 Commerce Street
Dallas, TX 75242
Comm: 214-767-8235
FTS : 767-8235

Texas
Arizona
Arkansas
Colorado
Louisiana
Montana
New Mexico
Oklahoma
Utah
Wyoming

Veterans Administration

Memorandum

Date:

From:

Subj: COST PER UNIT

To:

		1987	1988	1989
OUTSIDE MARKET	Pamelor 25mg 500/BT	83.24	103.84	114.23
	Parlodel 5mg 100/BT	94.15	97.95	107.75
	Tonocard 400mg 100/BT	36.97	43.87	48.26
	Vasotec 5mg 100/BT	45.90	50.44	53.97
	Vasotec 10mg 100/BT	48.20	52.97	56.68
	Vasotec 20mg 100/BT	68.56	75.34	80.61
	Clinoril 150mg 100/BT	48.19	49.46	53.91
	Calan S/R 240mg 30/BT	N/A	16.01	17.57
	Depakote 250mg 100/BT	22.92	25.67	28.08
	Betagan 0.5ml 5ml	6.32	8.45	9.15
	Capoten 25mg 1000/BT	273.08	286.73	315.40
	Capoten 50mg 1000/BT	455.17	477.92	525.71
	Capoten 100mg 100/BT	80.49	78.88	87.64
	Corgard 40mg 1000/bt	333.61	370.55	405.38
	Retrovir 100mg 100/BT	N/A	N/A	150.24
	Atrovent Inhaler	N/A	11.98	11.98
ISSUE	Cardizem 30mg 100/BT	N/A	17.03	17.19
	Cardizem 60mg 100/BT	N/A	27.69	28.41
	Tagamet 300mg 100/BT	38.59	38.59	27.64
	Lopressor 50mg 1000/BT	91.83	119.38	118.14
	Zantac 150mg 60/BT	N/A	37.71	35.49
	Dyazide 1000/BT	89.28	89.28	87.53
DEPOT	Tenormin 50mg 100/BT	27.08	N/A	27.29
	Tenormin 100mg 100/BT	40.78	N/A	40.37
	Tagamet 400mg 60/BT	30.58	29.87	29.87
	Cardizem 90mg 100/BT	N/A	N/A	41.01
	Lopid 300mg 100/BT	N/A	19.61	19.61
	Naprosyn 250mg 100/BT	N/A	28.19	28.19
	Naprosyn 375mg 100/BT	N/A	34.20	34.20
	Naprosyn 500mg 100/BT	N/A	42.17	42.17
	Trental 400mg 100/BT	21.48	21.48	21.48

ATTACHMENT J

VA FORM
SEP 1984 2105

Veterans
Administration

Memorandum

March 20, 1989

Date:

From:

Subj: Observations and Conclusions

To:

Although the survey contained a small sample of medications dispensed, several conclusions can be arrived at from this study. Outside market sources have shown a trend toward increased costs in 1988 and 1989. All of the major pharmaceutical companies have raised their prices approximately 10% in 1989. About 30% of the Outpatient Budget is allocated toward these purchases. Where it use to cost $200,000.00 a quarter for those items, we can expect to spend $220,000.00 for the same medications.

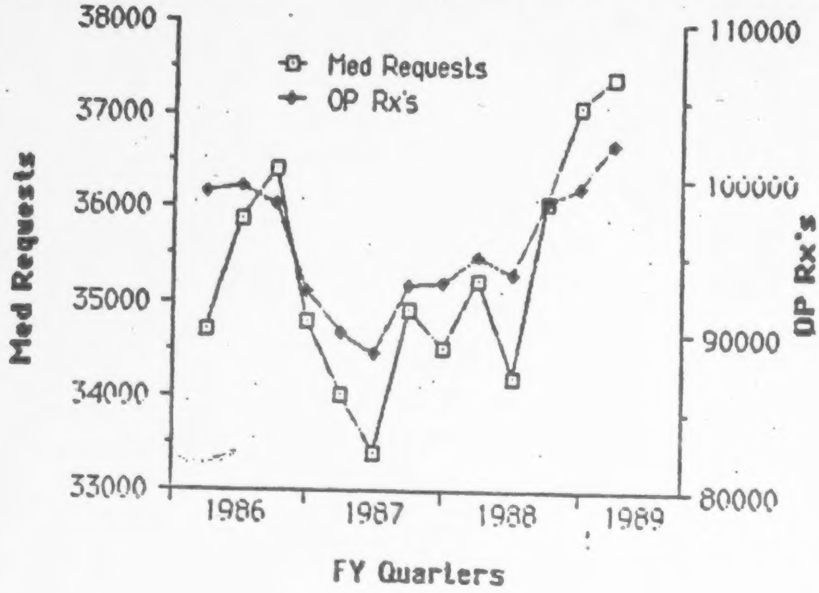
The number of units dispensed increased in 1988 as compared to 1987. The assumption to be made is that this trend will also continue. The combined effect of increased cost and usage will have a major impact on the budget in the future.

Price stability can be seen in most items that are purchased from DEPOT. However, in the future there may also be price increases as old contracts expire and new ones are bid on.

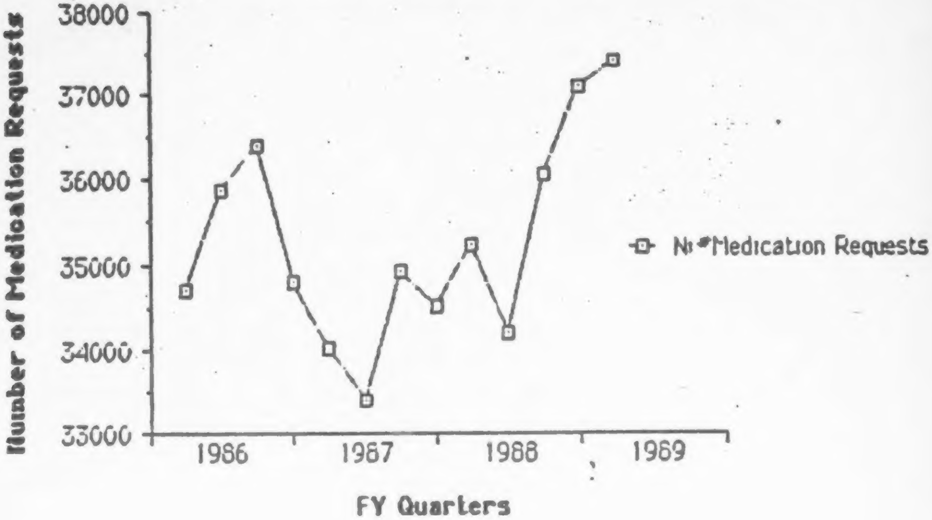
The coming year does not hold for any significant decrease in either drug costs or the number of units dispensed. New modalities are being added to the formulary without the elimination of old ones. It can also be expected that out patient treatment for specific disease states such as AIDS will increase, impacting furthur on our resources.

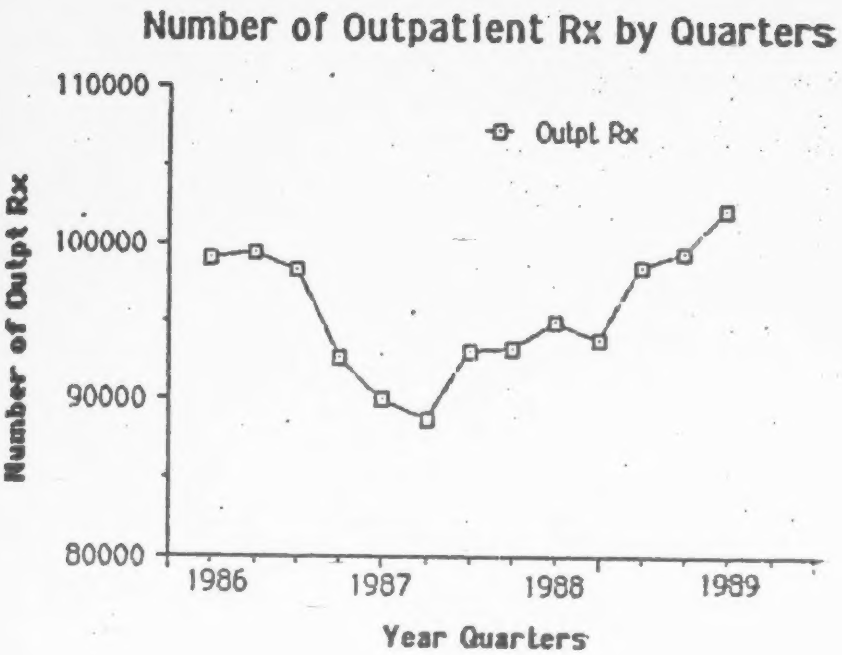
Donald L. Newton R.Ph.

VA FORM
SEP 1984 2105



*Med Requests and OP RX's By FY Quarters


Number of Medication Requests by FY Quarters


Number of Outpatient Rx by Quarters
110000
100000
90000
80000
Number of Outpt Rx
Outpt Rx
1986
1987
1988
1989
Year Quarters

COUNTY OF SUFFOLK

COUNTY LEGISLATURE

ROSE CARACAPPA
COUNTY LEGISLATOR, 4TH DISTRICT

CHAIRMAN:
VETERANS AFFAIRS COMMITTEE

MEMBER:
ENERGY & ENVIRONMENT
FINANCE & EDUCATION
PUBLIC SAFETY
SENIOR CITIZENS

248 MIDDLE COUNTRY ROAD
SUITE 03
SELDEN, NEW YORK 11784-2817
(516) 732-2000

May 15, 1989

HOUSE COMMITTEE ON VETERANS AFFAIRS
U.S. House of Representatives
Washington, DC 20515

Re: Congressional Field Hearing, VAMC Northport

Dear Hearing Panel,

I will not speak of the significant and sometimes total sacrifice our veterans have made, and continue to make, on behalf of the freedom you and I both share. And I do not have to remind you that their wounds and disabilities have prevented many of them from taking advantage of the opportunities that both you and I enjoy and sometimes take for granted. Freedom, as you must know, is never free. The price is high. Our veterans have paid that price and have never let us down. It angers me when Congress declares that the cost of veterans is too high. Congress creates veterans. Our veterans suffered at the hands of the enemy. Must they now suffer at the hands of their own government? Our veterans cannot sacrifice any more. It is your responsibility that each veteran receives essential services in a appropriate and timely fashion. Don't let them down. Budget restraints is a poor excuse. Remember, in times of war Congress always appropriates enough money for bullets and bombs.

I have been inundated, on a regular basis, with complaints from veterans about their treatment or lack of it at the VAMC at Northport. I could list many individual cases, but I'm sure you've heard it all before. Many times we are quick to judge and complain and point our fingers at the administration and staff at Northport. But in detailed review, the path always seems to lead back to Congress, and the lack of appropriate funding.

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On Long Island, our VA Medical Center at Northport serves a veterans population of staggering proportion. Long Island's veteran population exceeds any other geographic location in the United States. The VAMC cannot meet minimum standards of service delivery without appropriate funding. The intent of Congress is to have the VA meet its mandated and moral obligations to this country's veterans. Congress has allowed the Office of Management and Budget to circumvent that intent. Will Congress allow the OMB to again, with the ridiculously low FA1990, to undermine the intent of Congress?

A Registered Nurse can walk into any other hospital and receive $6-10000 more per year. The nurse to patient ratio is frighteningly low. The OMB's answer is to close entire wards because they can't staff them and, ironically, fire almost 9000 fulltime medical and research employees.

The answer to the problem does not lie in commissioning more time-consuming studies. The answer does not lie in additional Congressional Hearings. You cannot waste more time on reports. To do so would be to mislead and deceive. You cannot wait any longer. The veterans are running out of time. You already know what the answer is - appropriate more money.

There are 28 million living veterans, 10 million of whom have reached an age where they need at least some kind of geriatric care. Approximately 200,000 New York State residents are senior veterans and are now or will soon be in need of short or long term care. A state-funded long-term veterans care facility will open in the future at SUNY Stony Brook. The VAMC Northport has been removing beds at a regular rate since the Graham-Rudman Act. With the addition of the new home at SUNY and the loss of beds at Northport there may be a total of 40 new beds available. Where do the other 199,960 veterans go? The whole precept reads like some bad joke.

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I haven't even mentioned the needs of the other 18 million veterans, a large percentage of whom have currently or will someday require the services of the VA.

Considering the fact that the VA is experiencing a $600 million to $1 billion shortfall with no sign of a remission in its financial health, I strongly urge you to consider the following suggestions:

1) Exempt the VA from budgetary restrictions under the Balanced Budget and Emergency Deficit Act of 1985.

2) To eliminate the VA budgetary shortfall Congress must immediately pass a supplemental appropriation.

3) Give very serious attention to the DAV's "VA/DoD Health Care Alliance" proposal.

4) Considering the saturation of veterans in the Long Island area, target the VAMC at Northport for immediate emergency appropriations to upgrade and enhance services and delivery.

****

Although this hearing is specifically directed at VA funding and health care I would like to take this opportunity to touch on two related issues:

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Firstly, as I stated before, Long Island has a staggering veteran population. It is a marked inequity that we have no representation on either the House or the Senate Committee on Veterans Affairs. As a matter of fact the whole of New York State lacks a single seat on those Committees. Congress should reconsider the committee selection process to allow for more adequate representation of the majority of veterans who will be affected by decisions made in those committees.

Secondly, I have received many complaints about lost or misplaced service and medical records. Timely acquisition and file location of records must become a priority. A veteran is usually in a grave situation when the need arises for his or her records.

Thank you for your kind consideration to these remarks.

Sincerely,

Rose G. Caracappa

Rose Caracappa
County Legislator, 4th District

May 15, 1989

Laurel Keating
1112 Washington Drive
Centerport, NY 11721

The VA Hospital is the most tangible and necessary benefit that the USA offers those who have served when they need it most. We must maintain this, of all, services.

May 15, 1989

Cathy Mendygraw
N. Y. Federal Executive Board
26 Federal Plaza
New York, NY 10278

The New York Federal Executive Board would like to present our two published reports, "New York's Not So Quiet Federal Employment Crisis", and "New York City/Nassau/Suffolk Counties Special Salary Rate Request", which deal with the severe recruitment and retention problems which federal agencies are facing in New York City and Long Island (including the VA). We would like these reports to be included as part of the hearing testimony.

NEW YORK'S "NOT SO QUIET" FEDERAL EMPLOYMENT CRISIS

A REPORT OF

THE NEW YORK FEDERAL EXECUTIVE BOARD

APRIL 1988

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EXECUTIVE SUMMARY

Federal agencies in New York City, Nassau and Suffolk Counties are facing a staffing crisis. In January 1988, the New York Federal Executive Board established a work group of agency representatives to analyze and report on this crisis. A summary of their findings and recommendations follows.

THE PAY GAP

The Federal government is at a double disadvantage in the New York area. New York City and Long Island have seen unprecedented private-sector job growth while Federal pay levels have increasingly lagged behind the private sector. The tight local labor market combined with the pay disparity between the Federal Government and other New York area public and private employers is resulting in severe recruitment and retention problems for all Federal agencies in the area.

THE COST OF LIVING PROBLEM

The cost of living in the New York area is the highest in the nation. For the year ending November 1987, consumer prices in the New York/Northeastern New Jersey region rose 6.3%, the largest annual increase among 15 major metropolitan areas in the United States. Federal workers' salaries are subject to a degree of strain that is unknown in the rest of the country. A substantial number of Federal employees are leaving the Federal workforce for better pay as they are unable to maintain a decent standard of living on a Federal salary in the New York area.

RECRUITING AND STAFFING ISSUES

Agency testimony verifies that the staffing shortage is reaching crisis proportions. Agency officials report critical staffing shortages in their professional, administrative, technical, and clerical ranks. Many of these vacancies exist in spite of special salary rates and innovative recruitment campaigns. Agencies also experience unusually high attrition and turnover rates as their employees are lured away by higher paying private, state and city employers.

EMPLOYER OF LAST RESORT?

Federal jobs are not considered as career alternatives by the majority of college graduates in the New York area. A number of college placement directors and counselors indicate that the majority of their graduates are not interested in Federal employment due to the sub-standard starting salaries the Federal government offers. Agencies verify that they cannot attract and recruit enough recent college graduates to fill their critical vacancies.

QUALITY OF CANDIDATES

The quality of candidates that New York Federal agencies are attracting is deteriorating. Agency officials report the inability of candidates to pass OPM examinations and agency training programs. These officials are concerned about the potential impact this lower quality workforce will have on agency operations.

IMPACT ON SERVICES

The staffing crisis is having an adverse impact on New York Federal agencies' mission accomplishment. Agencies cite examples of loss of productivity, increased administrative costs, and a decline in services to the public. In addition, the lack of well-qualified candidates for key positions has led to the "deprofessionalization" of some segments of the workforce.

RECOMMENDATIONS

The New York Federal Executive Board urges that an area pay differential of at least 25% be implemented without delay in order to enable Federal agencies to compete with other New York employers. This differential would be payable to General Schedule, Merit Pay, and Senior Executive Service employees based in New York City and Nassau and Suffolk Counties. There is a strong conviction in the New York Federal community that unless this action is taken we are inviting serious deterioration in Federal programs in the metropolitan area.

NEW YORK'S "NOT-SO-QUIET" FEDERAL EMPLOYMENT CRISIS

> "We are beginning to get the quality of government that we're willing to pay for."[1]

Federal agencies in the New York area are facing a staffing crisis. A variety of economic and social factors are combining to push the Federal community past mere concern and into a posture of immediate action to salvage the integrity of the Federal workforce in New York. In January 1988, the New York Federal Executive Board established a work group of agency representatives to study and report on this crisis. Based on the group's findings, which follow, the New York Federal Executive Board proposes a pay adjustment for General Schedule, Merit Pay and Senior Executive Service employees in New York City, Nassau and Suffolk County Federal agencies.

THE PAY GAP

> — "Unless something is done to reduce the disparity in pay between the public and private sectors, it's an obstacle [in attracting and retaining a qualified workforce]." [2]

The Federal Government is at a double disadvantage in the New York area: New York City and Long Island have seen unprecedented private sector job growth, while Federal pay levels have increasingly lagged behind the private sector. As a consequence, agencies are experiencing extraordinary difficulty attracting and retaining qualified staff in all categories of positions from clerical through professional.

In the Federal job arena, New York City and Nassau and Suffolk Counties have a non-military, non-postal population of 36,391[3] (General Schedule and non-General Schedule), working in 49 departments and agencies. Seventy-five percent of that population is located in New York City proper. The largest employee populations are in the Departments of Treasury, Justice, Health and Human Services, and in the Veterans Administration. In addition, the Postal Service employs 52,460, bringing the total civilian Federal population in New York City, Nassau and Suffolk Counties to 88,851.

Overall in New York City the number of private and public sector jobs rose by 48,000 in the first ten months of 1987. This continued a pattern of increases which have averaged about 1.7% a year since the end of 1982, raising the New York City job total past the 3.6 million mark, its highest point since mid-1971. Private sector increases accounted for 94% of new jobs in 1987 and local government accounted for virtually all of the remainder. On Long Island, jobs rose by 17,000 during the same period for a 1987 job-growth rate of 1.9%. In sharp contrast to the impressive growth in the rest of the labor market, Federal employment in New York City, Nassau and Suffolk Counties showed a net increase of only 670 jobs in 1987. The New York City unemployment rate for 1987 averaged 5.8% -- a 17-year low, and unemployment on Long Island was 3.4%.[4]

Private-sector job growth plus low unemployment add up to a competitive job market. The Federal Government, with pay levels 23.7% behind comparability by January 1988,[5] is in no position to compete with either the private sector or state and local government in New York, all of whom offer higher salaries as evidenced by CHARTs 1 and 2. In reviewing the charts, pay particular attention to the dramatic disparity between nationwide Federal average salaries and the New York City and nationwide average private salaries. In fact, New York City average private salaries range from 18% - 66% higher.

In addition to the General Schedule, there are 23 other pay plans (see Appendix A) in force in the New York City/Long Island Federal community. Fifteen per cent of the non-postal population is paid on a plan other than the General Schedule. Of the 85% who are on the General Schedule, 14% are paid under special salary rates. In fact, when the Postal Service is included, a full 70% of the NYC/LI Federal work force is paid at rates other than the normal General Schedule rate.

When comparing the General Schedule employees to their counterparts in other white collar pay plans in the the Federal community, salaries lag pitifully behind. The average salary for General Schedule employees in New York and Long Island (including Merit Pay employees and those receiving special salary rates) is $26,747. The average salary of all other white collar pay plans is $38,898 -- a full 45% higher.

Not only is the Government at a disadvantage in the salary area, Federal employees do not receive the range of benefits typical of other employers in New York. These include fully-paid health insurance, short-term disability coverage, paid life insurance, comprehensive dental benefits, maternity leave, and funeral leave.

CHART 1

AVERAGE SALARY COMPARISON CHART

OCCUPATION	FEDERAL GS GRADE	NATIONWIDE AVERAGE FEDERAL SALARY	NATIONWIDE AVERAGE PRIVATE SALARY **	PERCENT ABOVE FEDERAL AVERAGE	NEW YORK CITY AVERAGE PRIVATE SALARY ***	PERCENT ABOVE FEDERAL AVERAGE
ENGINEER	GS-05	$21,419	$28,958	35%	$35,534	66%
	GS-07	$26,620	$32,295	21%	$36,287	36%
	GS-09	$32,569	$37,235	14%	$41,842	28%
	GS-11	$35,460	$44,360	25%	$49,855	41%
	GS-12	$38,866	$52,698	36%	$56,446	45%
ACCOUNTANT	GS-05	$16,783	$21,527	28%	$24,177	44%
	GS-07	$20,817	$25,984	25%	$29,189	40%
	GS-09	$25,289	$32,074	27%	$36,038	43%
	GS-11	$30,811	$40,611	32%	$45,639	48%
	GS-12	$37,243	$51,144	37%	$54,908	47%
PROGRAMMER	GS-05	$16,783	$17,690	5%	$19,861	18%
	GS-07	$20,817	$25,441	22%	$28,579	37%
	GS-09	$25,289	$30,320	20%	$34,066	35%
	GS-11	$30,811	$36,422	18%	$40,928	33%
	GS-12	$37,243	$44,693	20%	$50,230	35%
JOB ANALYST	GS-05	$16,783	$22,642	35%	$25,431	52%
	GS-07	$20,817	$25,615	23%	$28,774	38%
	GS-09	$25,289	$30,749	22%	$34,548	37%
	GS-11	$30,811	$39,326	28%	$44,194	43%
	GS-12	$37,243	$47,021	26%	$52,848	42%
DIR. OF PERSONNEL	GS-13	$44,797	$65,106	45%	$68,730	53%
	GS-14	$53,309	$78,123	47%	$81,614	53%
ATTORNEY (GENERAL)	GS-09	$25,289	$32,022	27%	$35,980	42%
	GS-11	$30,811	$41,319	34%	$46,435	51%
	GS-12	$37,243	$52,158	40%	$55,911	50%
	GS-13	$44,797	$65,944	47%	$69,560	55%
	GS-14	$53,309	$80,856	52%	$84,322	58%
GENERAL CLERK	GS-04	$14,727	$19,987	36%	$22,523	53%
COMPUTER OPERATOR	GS-05	$16,783	$17,690	5%	$19,899	19%
	GS-06	$18,980	$22,207	17%	$24,941	31%
DATA ENTRY OPERATOR	GS-03	$14,705	$16,931	15%	$19,032	29%
PERSONNEL CLERK	GS-05	$16,783	$20,158	20%	$22,637	35%
SECRETARY	GS-05	$17,030	$18,769	10%	$21,132	24%
	GS-06	$18,980	$21,745	15%	$24,422	29%
TYPIST	GS-03	$14,705	$17,218	17%	$19,360	32%

** NATIONAL SURVEY OF PROFESSIONAL, ADMINISTRATIVE, TECHNICAL, AND CLERICAL PAY: PRIVATE SERVICE INDUSTRIES, MARCH 1987, U.S. DEPARTMENT OF LABOR BUREAU OF LABOR STATISTICS, DECEMBER 1987, BULLETIN 2290

*** THE ECONOMIC RESEARCH INSTITUTE, GEORGRAPHIC ASSESSOR, FEBRUARY 15, 1988

CHART 2

ENTRY LEVEL SALARY COMPARISON CHART

OCCUPATION	FEDERAL GS GRADE	FEDERAL ENTRY LEVEL SALARY	NYC GOV'T ENTRY LEVEL SALARY **	% ABOVE FEDERAL SALARY	NYS GOV'T ENTRY LEVEL SALARY **	% ABOVE FEDERAL SALARY
ENGINEER *	GS-05	$19,268	$25,427	32%	$22,289	16%
	GS-07	$23,866	$26,501	11%	$29,256	23%
	GS-09	$29,199	$29,421	1%	$36,111	24%
	GS-11	$31,383	$34,924	11%	$42,363	35%
	GS-12	$33,979	$38,478	13%	$45,696	34%
ACCOUNTANT	GS-05	$15,118	$20,924	38%	$21,070	39%
	GS-07	$18,726	$23,632	26%	$23,565	26%
	GS-09	$22,907	$26,162	14%	$26,354	15%
	GS-11	$27,716	$29,138	5%	$34,260	24%
	GS-12	$33,218	$31,469	-5%	$38,123	15%
COMPUTER PROGRAMMER	GS-05	$15,118	$21,341	41%	$21,070	39%
	GS-07	$18,726	$26,652	42%	$26,354	41%
	GS-09	$22,907	$31,092	36%	$34,260	50%
	GS-11	$27,716	$34,644	25%	$38,128	38%
	GS-12	$33,218	$42,632	28%	$42,363	28%
JOB ANALYST	GS-05	$15,118	$17,000	12%	$19,902	32%
	GS-07	$18,726	$20,817	11%	$21,916	17%
	GS-09	$22,907	$27,832	21%	$26,404	15%
	GS-11	$27,716	$36,532	32%	$34,276	24%
	GS-12	$33,218	$38,468	16%	$41,124	24%
ATTORNEY (GENERAL)	GS-09	$22,907	$32,483	42%	$24,530	7%
	GS-11	$27,716	$34,691	25%	$29,649	7%
	GS-12	$33,218	$44,111	33%	$38,128	15%
	GS-13	$39,501	$47,988	21%	$45,696	16%
	GS-14	$46,679	$51,864	11%	$50,593	8%
GENERAL CLERK	GS-04	$13,513	$15,336	13%	$14,844	10%
COMPUTER OPERATOR	GS-05	$15,118	$18,893	25%	$17,589	16%
	GS-06	$16,851	$20,817	24%	$20,066	19%
DATA ENTRY OPERATOR *	GS-03	$14,946	$15,610	4%	$14,042	-6%
PERSONNEL CLERK	GS-05	$15,118	$18,932	25%	$16,611	10%
SECRETARY *	GS-05	$16,798	$17,512	4%	$19,732	17%
	GS-06	$17,623	$18,932	7%	$23,402	33%

* FEDERAL SALARIES REFLECT SPECIAL RATES FOR THESE POSITIONS
** SALARIES FOR POSITIONS WITH COMPARABLE TRAINING AND EXPERIENCE REQUIREMENTS

THE COST OF LIVING PROBLEM

> ". . . Although people do not go to work for the Government to get rich, civil servants are increasingly unable to afford what they regard as the necessities of life . . . ."[6]

The comparatively low level of Federal pay puts employees at a distinct disadvantage in attempting to cope with the high cost of living in the New York metropolitan area. For the twelve months ending November 1987, consumer prices in the New York/Northeastern New Jersey region[7] rose 6.3%, the largest annual increase among 15 major metropolitan areas of the United States.

As CHARTs 3 and 4 indicate, New York Federal workers' salaries are subject to a degree of strain that is unknown in the rest of the country. Monthly housing costs for both ownership and rental are the highest in the nation. Energy costs are higher than elsewhere in the United States and have been for many years. The overall cost of living in New York is higher than any other key city with the possible exception of Anchorage, Alaska, a city supplemented by a 25% COLA. New York's state and city income taxes, at 8.375% and 4.2% respectively, are among the highest in the nation. The City sales tax, at 8.25% and no longer tax deductible, is astronomical and particularly affects the lower salaried employees. Property taxes in New York and surrounding suburban counties are acknowledged as the highest in the nation as indicated in CHART 4.

CHART 3 *

THE AVERAGE NEW YORK GS SALARY IS $26,747.00.
IF AN EMPLOYEE RELOCATES TO ANOTHER FEDERAL CITY AT THIS SALARY AND MAINTAINS AN IDENTICAL LIFESTYLE, HE/SHE WILL BE ABLE TO SAVE MONEY BECAUSE OF COST OF LIVING DIFFERENCES:

CITY	EARNS	SPENDS	DISCRETIONARY INCOME
KANSAS CITY	$26,747	$19,999	$6,748
ATLANTA	$26,747	$20,206	$6,541
NATIONAL AVERAGE	$26,747	$20,537	$6,210
DENVER	$26,747	$20,575	$6,172
DALLAS	$26,747	$20,768	$5,979
CHICAGO	$26,747	$21,943	$4,804
SEATTLE	$26,747	$22,133	$4,614
PHILADELPHIA	$26,747	$23,577	$3,170
WASHINGTON, DC	$26,747	$23,786	$2,961
SAN FRANCISCO	$26,747	$25,777	$970
HONOLULU	**	$25,990	**
BOSTON	$26,747	$26,173	$574
NEW YORK	$26,747	$26,747	$0
ANCHORAGE	**	$27,244	**

* ECONOMIC RESEARCH INSTITUTE, NEWPORT BEACH, CA, FEBRUARY 15, 1988

** EMPLOYEES IN HONOLULU & ANCHORAGE RECEIVE 22.5% & 25% COLAS RESPECTIVELY. IF OUR EMPLOYEE MOVED TO HONOLULU, HIS/HER SALARY WOULD BE $32,765. IN ANCHORAGE, HE/SHE WOULD RECEIVE A SALARY OF $33,434.

CHART 4

HOUSING COSTS IN KEY FEDERAL CITIES *

HOME OWNERSHIP

CITY	AVG. HOME PRICE	EST. MORT. PAYMENT	ANNUAL PROPERTY TAXES	MONTHLY UTILITIES	TOTAL MONTHLY OWNERSHIP COST	PERCENT OF NY COST
KANSAS CITY	$83,500	$748	$1,141	$145	$988	38%
DENVER	$94,800	$849	$1,181	$142	$1,089	42%
NATIONAL AVERAGE	$95,566	$856	$1,100	$156	$1,104	43%
SEATTLE	$110,000	$985	$857	$88	$1,144	44%
ATLANTA	$98,000	$878	$1,100	$182	$1,152	45%
CHICAGO	$115,000	$1,030	$578	$175	$1,287	50%
DALLAS	$124,000	$1,111	$857	$171	$1,353	52%
ANCHORAGE **	$129,000	$1,140	$1,548	$140	$1,409	54%
PHILADELPHIA	$138,000	$1,236	$1,100	$256	$1,584	61%
WASHINGTON, D.C.	$148,000	$1,326	$1,303	$196	$1,631	63%
HONOLULU ***	$184,060	$1,649	$1,262	$176	$1,930	75%
BOSTON	$212,000	$1,899	$1,222	$195	$2,196	85%
SAN FRANCISCO	$246,200	$2,205	$1,222	$77	$2,384	92%
NEW YORK	$246,000	$2,203	$1,587	$292	$2,591	100%

RENTAL

CITY	TOTAL MONTHLY RENTAL COST	PERCENT OF NY COST
SEATTLE	$795	39%
KANSAS CITY	$834	41%
DENVER	$880	43%
NATIONAL AVERAGE	$925	45%
ATLANTA	$1,013	49%
CHICAGO	$1,075	52%
DALLAS	$1,106	54%
ANCHORAGE **	$1,250	61%
WASHINGTON, D.C.	$1,298	63%
HONOLULU ***	$1,412	69%
SAN FRANCISCO	$1,419	69%
PHILADELPHIA	$1,427	69%
BOSTON	$1,606	78%
NEW YORK	$2,057	100%

* GEOGRAPHIC ASSESSOR, ECONOMIC RESEARCH INSTITUTE, NEWPORT BEACH, CA, FEBRUARY 15, 1988

** 25% COLA

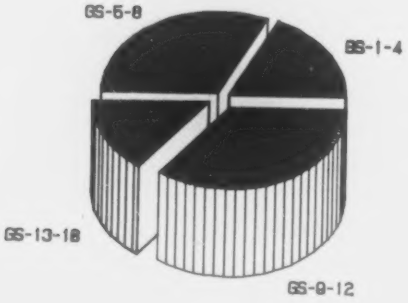
*** 22.5% COLA

The New York/Northeastern New Jersey cost of living in autumn 1981, as estimated by the Bureau of Labor Statistics (BLS), was the highest in the mainland United States. Since 1981, which was the last time BLS reported this four-person family budget data, consumer prices in the New York/Northeastern New Jersey area have gone up 30% as compared with 22% nationally, underscoring the fact that this region is the highest-cost non-COLA area in the nation. If we extrapolate from the 1981 data using the changes in the Consumer Price Index since then, we can roughly estimate the 1988 cost of living for a family of four:

STANDARD OF LIVING	1981	1988
Low	$15,705	$20,432
Intermediate	$29,540	$38,432
High	$47,230	$61,446

Of the 31,044 full-time permanent General Schedule employees in New York City and Long Island, half are at GS-8 and below; the majority of these are at or below GS-5. In fact, using step 5 of each grade level as a representative rate, 48% of General Schedule salaries in New York fall below the $20,432 necessary for even a low standard of living.

NY GENERAL SCHEDULE EMPLOYMENT BY GRADE



A substantial number of Federal employees, unable to maintain a decent standard of living, are leaving the Federal government for better pay. The Federal government in the New York/Long Island region is well on the way to assuming the uncoveted title of "employer of last resort."

RECRUITING AND STAFFING ISSUES

> "The Government . . . is increasingly unable to attract, to retain and to motivate the kinds of people it will need to do the essential work of the republic."[8]

Personnel officials and administrators from twenty-one metropolitan New York City and Long Island Federal agencies were interviewed regarding their recruiting and staffing problems. All of the agencies report critical staffing shortages in their professional, administrative, and technical ranks including positions which were formerly covered by the Professional and Administrative Career Examination (PACE). Many of these vacancies exist in spite of special salary rates. The agencies cannot attract enough external candidates to fill their vacancies despite extensive recruiting efforts. They cite the Federal government's non-competitive entry-level salaries as the main cause of this problem. Even those agencies with direct-hire authority report discouraging recruitment results, in addition to the extra administrative burdens and expense which the direct-hire authority entails. Agencies that do initially attract recruits experience a high attrition and turnover rate as their employees are lured away by higher paying private, state and city positions.

- The Army Corps of Engineers reports a drastic 40% turnover rate for engineers in FY 1987 in two of its major divisions in New York.
- Metropolitan area Veterans Administration Hospitals, with approximately 50-60% of their workforce on the VA pay plan or special salary rates, still experience critical vacancies in their medical and health related positions.
- The Environmental Protection Agency reports that during FY 1986-1987 they lost one-third of their New York workforce, many to the private sector and state and local governments. Their staffing losses include the entire gamut of employees from GS-2 through GM-15, including many receiving special salary rates.

- The Federal Aviation Administration reports that air traffic controllers are unwilling to transfer to New York facilities because they experience an immediate and substantial drop in spendable income in this high-cost area. Other agencies, including the U.S. Coast Guard, Department of Labor, and the U.S. Customs Service have a similar problem with potential transferees.

- The Federal Bureau of Investigation has experienced a three year trend of increased resignations by agents assigned to the New York area. Due to the high cost of living here, the New York Regional Office ranks last as the assignment of choice among the agents employed by the Bureau. In an effort to remedy this situation, the FBI has proposed a pay adjustment for agents based in New York.

- All the New York agencies unanimously state that they have substantial difficulty recruiting and retaining clerical employees despite the special clerical salary rates. The clerks that are hired typically receive training, at government expense, in office skills and word-processing and then leave to take private-sector jobs with higher salaries and better benefits.

The dearth of well-qualified applicants for New York Federal positions has prompted the metropolitan area agencies to initiate a variety of innovative recruitment campaigns. In addition to extensive newspaper advertising at local and nationwide levels, some agencies have utilized radio announcements, job fairs, job announcements in professional and trade journals, as well as intensive college campus recruitment activity. One major agency has revamped its entire advertising campaign, produced a recruitment videotape, developed a recruiter training course, and performed various studies to improve recruitment methods. However, despite these efforts, agencies report minimal success in recruiting qualified personnel to fill their vacancies.

EMPLOYER OF LAST RESORT?

"Grads go for the money."9

A number of colleges and universities in the metropolitan New York City recruiting area were contacted in order to ascertain the average entry-level salaries their graduates command in the private sector, the typical professions they enter, and their overall perception of Federal employment. All of the college placement directors and counselors indicated that the majority of their graduates were not interested in Federal employment due to the sub-standard starting salaries. Several stated that their students cannot afford to accept Federal positions due to the high cost of living in the metropolitan area and the fact that many of the graduates have student loans to repay.

A placement counselor from Fordham University's College of Business said frankly that Federal jobs are the "last resort" for students as over 50% of their accounting graduates secure positions with the "Big 8" accounting firms. A few other counselors indicated that some graduates did accept Federal jobs with the Internal Revenue Service -- not for the salary, but for the experience. The Internal Revenue Service experience validates these statements as the agency loses many of its recruits to the metropolitan accounting firms after the employees complete their training.

A personnel official from the Social Security Administration reports that the agency cannot attract enough recent college graduates. In fact, during recruitment contacts with the City University of New York, agency recruiters were advised not to publicize positions with a GS-5 entry-level salary as these positions would not generate any interest from the colleges' student candidates. Thus, it has become extremely difficult, if not impossible, for the metropolitan Federal government agencies to attract, recruit and retain qualified people for their vacant positions.

QUALITY OF CANDIDATES

> "The idea that we can settle for mediocrity
> in our public services would, in time,
> become an invitation to mediocrity as a nation."[10]

New York agency officials report that they are attracting less-qualified applicants than in the past. These officials express concern regarding the potential impact this lower quality workforce will have on agency operations. In addition, since many agencies promote their managers and executives from within, there is also concern regarding the potential effect this workforce will have on the future managerial pool.

- The Social Security Administration reports that in New York many of the applicants for their Claims Representative and other positions cannot pass the OPM examinations. SSA also reports a higher than average failure rate in their training classes.

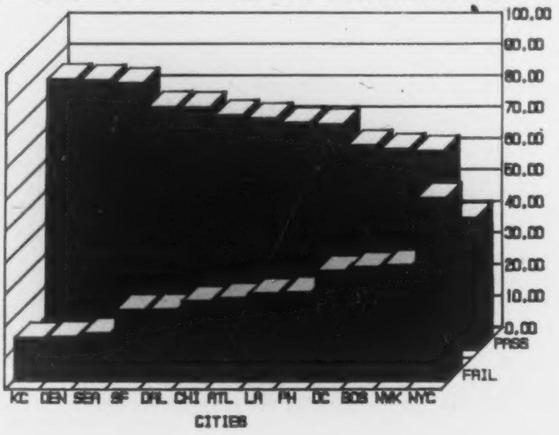
- The Internal Revenue Service states that it must hire and train two candidates for every New York vacancy as the agency experiences a 50% drop-out/failure rate in its training programs.

- The Immigration and Naturalization Service reports a 25% training failure rate among recently hired criminal investigators in the New York area.

- The Occupational Safety and Health Administration loses their best Industrial Hygienists and Safety Specialists to other New York employers shortly after completion of training, leaving less experienced employees to carry on operations.

The lack of quality applicants for clerical positions is evident in the results of the FY 1987 OPM Clerical Examination. The New York Area Office is the only office in the nation with a higher failure rate than passing rate. On a nationwide basis nearly 76% of the applicants pass the clerical examination, while in the New York area less than 42% of clerical applicants pass. The graph below provides further comparisons.

FY 1987 OPM CLERICAL EXAMINATION



The ultimate result of the Federal staffing crisis in New York can only be demoralization, and finally, serious deterioration in the quality of the Federal workforce here. When agency managers are forced to hire mediocre candidates because that's all they can get, then it is only a matter of time before agency programs suffer serious setbacks.

IMPACT ON SERVICES

> "This is a 'quiet crisis' because few people care about it 'until something happens.' Then, when a nuclear-power plant melts down, or an airliner crashes, or the stock market collapses, people suddenly want competent federal officials to find out what happened and to make sure it will not happen again."[11]

Agency officials here are concerned about the impact of this employment crisis on their agencies' mission accomplishment. The most visible and measurable impact is a decline in productivity and goals accomplishment. However, there is an underlying problem which has not yet been fully recognized. Because they are unable to recruit well-qualified candidates for key positions, agency officials have been forced to restructure jobs to fit the qualifications of available candidates for vacant positions. For instance, one agency's lack of recruits for engineers has led to the need to redesign the positions so that they can be filled by non-professionals. Other agencies' inability to recruit accountants has resulted in more accounting technicians being hired. While at first this may appear to be a cost-effective solution, in fact, the work is not being carried out with the professional approach originally intended. Consequently, tasks are processed rather than projects managed, resulting in a focus on short-term "quick-fixes" rather than long-term solutions. This lowering of standards further exacerbates recruiting difficulties as agencies lose credibility in the professional community.

Administrative costs have increased tremendously in New York due to the constant turnover of employees. Agencies which have experienced this high turnover state that training costs and costs per hire are at an all-time high. These turnover statistics are particularly disturbing when, as the Army Corps of Engineers reports, it can cost as much as $100,000 over two years to train an engineering intern. Overtime usage has also increased because of staffing shortages and increased workloads per employee.

Service to the public is invariably affected by the lack of number and strength in the Federal service. When there just aren't enough staff to answer telephones, or when employees are assigned more cases than they can handle, the people of New York are not receiving the attention that they have a right to expect. Veterans Administration hospitals report that due to the inability to fill their critical medical support positions, patient care has been adversely affected. Officials cite examples of delays in surgery due to a lack of Physician's Assistants; delays in updating of medical charts due to shortages of Medical Records Technicians; as well as other delays due to lack of qualified personnel. A recent New York Times article reported that the Internal Revenue Service's North Atlantic Region, headquartered in New York, had an error rate of 30.7%, the agency's highest, in answering taxpayer inquiries. We can expect to see more and more of these statistics as the crisis in New York's Federal agencies deepens.

RECOMMENDATIONS

> "The federal government cannot maintain a uniform pay scale nationwide and respond efficiently to local job market demands. The size and diversity of our economy simply does not allow it." 12

The Federal employment crisis in New York is not going to go away; it is getting worse. The unique economic conditions in this region must be addressed if we are to alleviate the critical staffing shortages in Federal agencies here. The quality of agency staff is declining and a vicious cycle has begun. If it is allowed to continue, Federal agencies' public images will further deteriorate, resulting in even less interest from quality candidates. Without the ability to revitalize the workforce, New York agencies will find it increasingly difficult to accomplish their missions.

The attempts which have been made to date to alleviate this problem have taken the form of special salary rates. As of September 1987, fourteen per cent of the General Schedule employees in New York City and Long Island were receiving special salary rates in response to demonstrated recruitment and retention problems. Requests are in process for special rates for Accountants, IRS Agents, Quality Assurance Specialists, and additional clerical positions; and are being contemplated for Social Security Claims Representatives. With more and more New York Federal employees on different special rate schedules, we are seeing increasing fragmentation of what is supposed to be a uniform pay system. Moreover, we are constantly confronting the untenable situation where the GS-4 Clerk-Typists (and the GS-3's above Step 1) are earning more under special rates than the entry-level professional and administrative employees in the same office.

The special rates approach flies in the face of the statutory mandate that pay distinctions be maintained in keeping with work and performance distinctions. The Federal Managers Association states in the 1987 Annual Report of the Advisory Committee on Federal Pay that piecemeal attempts to change the personnel system are acts of desperation to fix a system that does not work properly. Clearly, special salary rates are not working in the New York City/Long Island area. The combined impact of the salary disparity and the cost of living affects all General Schedule employees. The only equitable and manageable solution is to follow the lead of many major employers and set salaries based on the local cost of living. A 25% differential for General Schedule, Merit Pay, and Senior Executive Service employees based in New York City, Nassau and Suffolk Counties would bring Federal salaries more in line with the higher rates paid by other local employers.

We cannot wait until a major operations failure results in a public outcry; we must address the crisis now. The answer lies in a competent and productive workforce. Federal agencies can only attract that workforce if they are able to compete in the local job market. The additional funds expended for salaries will be more than offset by being able to hire one qualified employee in the place of two or three marginal ones; by the increased revenue and other productivity gains generated by these employees; and by the ability to deliver more and better services to the people of New York. A 25% pay differential is essential, and the New York Federal Executive Board urges that it be implemented without delay.

NOTES

1/ David R. Gergen, Editorial, U.S. News and World Report, June 29, 1987.

2/ Bruce Laingen, quoted in Sean Ford, "Laingen Troubled by Dearth of Youth in Public Service." Federal Times, August 31, 1987, p. 12.

3/ Federal employment statistics shown in this report are from the Office of Personnel Management's Central Personnel Data File.

4/ U.S. Department of Labor, Bureau of Labor Statistics.

5/ Annual Report of the Advisory Committee on Federal Pay, August 19, 1987, p.16.

6/ Paul Volcker, quoted in Martin Tolchin, "Is Quality of Federal Work Force Deteriorating?" The New York Times, January 15, 1988, p. B6.

7/ This region includes the five boroughs of New York City, the New York Counties of Nassau, Suffolk, Westchester, Rockland and Orange; and twelve counties in Northeastern New Jersey.

8/ Paul Volcker, quoted in Robert A. Rankin, "The 'quiet crisis' in public service." Philadelphia Inquirer, January 31, 1988, p. 4-A

9/ Placement Director, Baruch College of the City University of New York, telephone interview, February 1988.

10/ Paul Volcker, quoted in Haynes Johnson, "Save Public Service." The Washington Post, January 15, 1988.

11/ Paul Volcker, quoted in Rankin, op. cit.

12/ Representative Tom McMillen (D-Maryland), quoted in Ruth Marlow, "Government grapples to fill job shortages." The Washington Times, October 22, 1987.

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APPENDIX A

PAY PLAN DEFINITIONS

AD	ADMINISTRATIVELY DETERMINED
CP	COMPTROLLER OF THE CURRENCY
ES	SENIOR EXECUTIVE SERVICE
FO	FOREIGN SERVICE OFFICER
FP	FOREIGN SERVICE PERSONNEL
GG	GRADES SIMILAR TO GS
GS	GENERAL SCHEDULE
NA	NONAPPROPRIATED FUNDS (NONLEADER)
NL	NONAPPROPRIATED FUNDS (LEADER)
SP	PARK POLICE
VC	CANTEEN SERVICE (VA)
VM	MEDICAL & DENTAL (VA)
VN	NURSING (VA)
VP	PODIATRISTS & OPTOMETRISTS (VA)
WD	WAGE - PRODUCTION FACILITATING - NONSUPERVISORY
WG	WAGE - NONSUPERVISORY
WL	WAGE - LEADER
WN	WAGE - PRODUCTION FACILITATING SUPERVISORY
WS	WAGE - SUPERVISORY
XD	PRINTING - PRODUCTION FACILITATING - NONSUPERVISORY
XL	PRINTING - LEADER
XP	PRINTING - NONSUPERVISORY
XS	PRINTING - SUPERVISORY

NOTE: SALARIES FOR U.S. POSTAL SERVICE EMPLOYEES ARE DETERMINED THROUGH COLLECTIVE BARGAINING.

New York City
Nassau/Suffolk Counties
Special Salary Rate Request

A Report Of
The New York Federal Executive Board

October 1988

NEW YORK CITY/NASSAU AND SUFFOLK COUNTIES SPECIAL SALARY RATE REQUEST

The New York Federal Executive Board is submitting a series-by-series documented justification for special salary rates for 81 series selected for study. In a memorandum to Constance Horner dated July 13, 1988, the FEB outlined a strategy for coping with the overwhelming task of documenting all New York occupations via the special salary rate procedure. This plan would have extended the results of a study of series comprising over 70% of the NYC/LI workforce to the entire workforce. However, OPM's August 26, 1988 response implied that such a strategy might not be employed.

The New York situation is so desperate that the FEB voted swiftly and unanimously to continue with the project, nonetheless. Agreement to extend the results of our sample to include all occupations would have been an effective means of handling this complex project. We recommend that the package be evaluated on that basis. However, it may also be reviewed on a series-by-series basis. The 81 series in this package are in addition to the 39 series already submitted by the FBI. Documentation for the remaining 204 series will follow if OPM chooses to evaluate the package on a series-by-series basis. It is necessary to consider special rates for all occupations because the nature of the recruitment and retention problem is clearly economic.

We contacted sixteen Departments and thirty-seven Independent Agencies in the NYC/LI area. We sought data and narrative information on recruitment/retention problems and agency certification for the special rates survey. Virtually every Department and Agency furnished the required statistical and narrative information and all stated their wholehearted support for this necessary effort.

We have enclosed forty (40) certification statements from the Independent Agencies and Departments who have verified that they have funding to support a 25% consolidated pay rate for all employees. Due to the scope and potential impact of this request, some agencies have withheld their funding (but not their endorsement) pending OPM's decision on this package. Other Departments and Agencies have delayed their certification of funding (but again, not their support) based on their interpretation of the August 12, 1988 Interagency Advisory Group (IAG) Executive Committee meeting convened by OPM. In fact, several agencies that had submitted their certification letters for this NYFEB effort, withdrew their funds certification.

We expect that OPM will work with the FEB in obtaining these delayed certifications. Based on the overwhelming evidence of recruitment and retention problems in the NYC/LI area as documented in this package, it is now time for OPM to move aggressively to implement the only short-term solution to our overwhelming and critical staffing problems.

SPECIAL RATE METHODOLOGY CONCERNS

The current method of demonstrating a staffing problem involves a "snapshot" of strength and vacancies as of two dates, and a count of employment offers, hires and losses between the two dates. We believe that this method does not necessarily provide a true picture of an agency's staffing situation. A more accurate picture would be shown by more frequent snapshots. The validity of the conclusions drawn would strengthen with each additional point in time measured. In fact, one Bureau of Labor Statistics official states that the current method ". . . is inadequate to make statistically adequate inferences."

The dynamic nature of staffing is not captured. For example:

- The fact that a position might have been vacant for six months of a "snapshot" period will not be reflected, as long as the job was filled at some point during the period.

- The "Offers Made" figure does not capture the many unproductive efforts necessary to yield each applicant who is worthy of receiving an offer.

- The "Quits for Pay" is not a reliable figure. Employees are often reluctant to state why they are resigning, listing such reasons as "personal" or leaving the form blank. Lateral moves out of New York City are often motivated by pay considerations, given the New York State and City tax structure and commuting/housing costs. This is recorded only as a "Reassignment, Change of Appointing Office" action on personnel documents, yet is often actually a quit for pay.

However, as this method is currently used as a measure for all special rates requests, we have drawn our conclusions from these statistics. There is a possibility, however, that problems may exist even if the statistics do not indicate a problem.

The issue of quality is addressed nowhere. Agencies are regularly forced to fill positions with less-than-qualified candidates.

- Recent clerical examination test results, reported by OPM, clearly demonstrate the agencies' inability to hire quality clerical employees. When 1,841 candidates applied for clerical jobs in New York City in the summer of 1988, only 504 or 27.4% were able to pass a test of simple reading and alphabetizing skills. Last year 42% of the New York applicants passed when on a nationwide basis 76% passed. This year's statisics reflect a further deterioration in the quality of new clerical applicants.

- The Internal Revenue Service routinely administers the AICPA skills test to all new Internal Revenue Agents. Test results in a recent exam showed that 72% of the norm group scored higher than the IRS population in the orientation test and 84% scored higher on the achievement test. Many employees in the New York area were among the lowest scorers in the IRS.

The gradual lowering of hiring standards is insidious, and there is great pressure to fill positions with someone.

NEW YORK LABOR MARKET CONCERNS

The extremely high cost of living in the New York City metropolitan area has been well-documented. However, it is important to note that it is this extraordinary cost of living which governs the wages and benefits which the private sector must offer to attract and retain a well qualified workforce. According to Homequity, Inc., the nation's largest corporate relocation firm, 50% of transfer offers to New York today are rejected, compared to 25% two years ago.

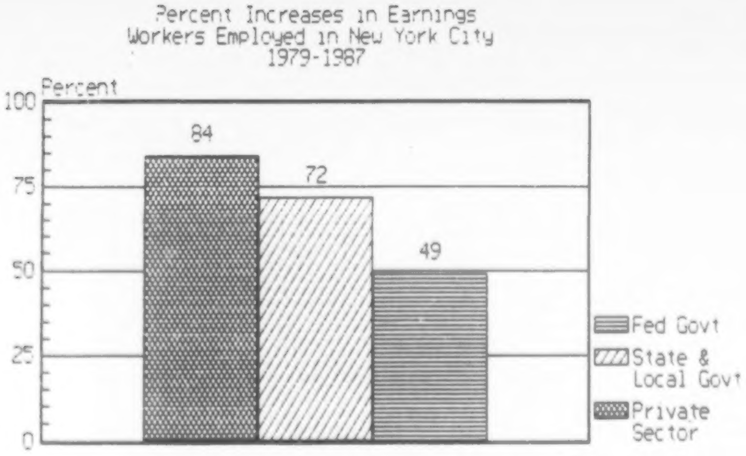
It is also this exorbitant cost of living which has led many private and public employers to offer COLA's in this area. The Federal Deposit Insurance Corporation hired Runzheimer and Company to develop a regional pay differential program for all FDIC locations. The New York metropolitan area received the highest differential rate in the nation - 19.2%. These differentials are updated annually based on cost-of-living changes. In addition, the Federal Reserve Board plans to abandon the General Schedule pay scale and opt for market pay levels to enable them to pay competitive salaries.

The federal government's inability to compete is exacerbated by the tight local labor market. The February 1988 New York City unemployment rate was 4.2%. The job growth in NYC has been primarily concentrated in white collar occupations, 80% of which are professional managerial, technical or clerical. According to the Bureau of Labor Statistics, 76% of the federal workforce is concentrated in these fields as opposed to 49% for the economy overall. The federal government in New York City is in direct competition with the leading growth sectors of the economy.

We have included comparative salary information for some occupational series. While we do not have salary data on all occupations, the trend is clear. Non-federal New York salaries are considerably higher than General Schedule pay rates for similar types and levels of work. The median difference in pay is well in excess of 25%, and is not confined to the entry levels of the various occupations. Private sector journey level and director level positions are also paid considerably more than equivalent General Schedule positions.

We are confident that if salary surveys were conducted for the occupations for which there are none available, the results would be similar, i.e. federal pay typically lagging by 25-45% (or more) behind metropolitan New York non-federal pay. With the meager pay increases to the General Schedule in recent years, the situation has deteriorated steadily.

It is not only the high-powered Fortune 500 corporations that make federal salaries pale in comparison. State and local government entities outpay the federal sector as well. In ten occupations ranging from accountant to engineer to job analyst, New York City and New York State salaries average 22.2% more than federal salaries. From 1979 - 1987 private sector earnings in New York City increased 84%, state and local earnings increased 72% and federal salaries increased only 48% as illustrated in the attached graph.



Source Bureau of Labor Statistics
U.S. Dept of Labor, 9/88

Although our poor competitive position in today's labor market is primarily caused by low salaries, we are also increasingly faced with applicants' questions regarding our benefit package. Salaries are only one of the ingredients, albeit an important one, in a total compensation package.

According to BLR Business and Legal Reports, Bureau of Law and Business, Inc. hospitalization and major medical insurance, which on average require federal employee contributions of 40%, are provided at no cost by 66% of the surveyed employers. It should also be noted here that 72% of the state and local government workers in this statistical survey had 100% of their hospitalization and major medical insurance paid by employer. Finally, 93% of all employers pay more than 65% of their employees' coverage. In most areas where benefits are compared, the federal worker is disadvantaged.

CONSOLIDATED RECRUITMENT AND RETENTION TRENDS

Recruitment and retention statistics for individual occupations often tell dramatic tales in terms of the turnover we are experiencing. Overwhelming evidence of New York's systemic problem is apparent when these statistics are consolidated. The surveyed occupations have been grouped in accordance with their PATCO categories (Professional, Administrative, Technical, Clerical and Other). We have also included summary data in total for all surveyed occupations.

SUMMARY FOR ENTIRE WORKFORCE

The overall recruitment and retention picture in New York is bleak. During the survey period (July 1, 1987 - June 30, 1988) a full one-third of all positions were vacant at one time or another. This annual vacancy rate (vacancies at the beginning of the period plus losses) is meaningful in demonstrating the stress under which the New York federal workforce is suffering. The revolving door of public servants in and out of the federal ranks in all categories is the root of the "Not-So-Quiet" federal employment crisis in New York. No organization can survive with a shrinking supply of institutional memory or the wooing away of its most capable journey level staff by private enterprise and state and local governments. This loss of technical knowledge creates a void of managerial talent for tomorrow. No organization can survive when all available candidates rush by our recruiting desks to compete for some of the highest paying jobs in the United States. This is the plight of the New York federal service.

PROFESSIONAL

Although different skills are required in the performance of the various professional occupations many characteristics of candidates are similar. In most instances these potential recruits are facing large student loan pay-backs. The federal salary in New York does not measure up in easing this burden. In a survey of college placement officers the noncompetitive salary vis-a-vis student loans was cited as a primary reason for rejecting a federal job offer.

During the survey period, almost 1/3 of the total number of positions were vacant at one time or another. At the GS-9 which is an entry level for a professional with a master's degree, nearly half (46%) of the total positions were vacant at some time during the year. Loss rates for all professionals at the typical entry levels of 5, 7 and 9 were an incredible 50%, 52% and 27% respectively. Even at the higher grade levels where the workforce is traditionally more stable, there were loss rates doubling and nearly tripling the national federal average of 6.36% *.

This mass exodus is being exacerbated by our inability to attract new recruits. Only 43% of formal employment offers were accepted. (This does not reflect the number of candidates who dropped out of the recruiting process before a formal offer was made.) We were able to fill only half of the positions that we tried to recruit for.

* Central Personnel Data File

Taken as a whole, the professional population of the federal service is being decimated. In nearly every grade level at least half of the losses were quits for pay**. Our recruiters are being told by candidates that pay is the problem at the entry level. The economic opportunities in New York are too attractive to ignore. "Public service be damned!", these people seem to say - they are trying to survive!

ADMINISTRATIVE

The occupations in the administrative series' are generally among the most stable in the federal workforce. In New York even this traditionally federal career-oriented group is subject to upheaval. An annual vacancy rate of 28% coupled with a positions filled success rate of less than two/thirds has brought about a crisis in these positions. The expanding real estate market has claimed housing specialists, appraisers and loan specialists; computer science positions abound in the non-federal employment market at high salaries so that there are no candidates for the federal government to choose from; no-one wants to transfer to New York as an air traffic controller; Criminal Investigators who are required to have a college degree have a starting salary which is lower than the high school graduate who becomes a local patrolman. These are some of the enticements in the ever expanding NY labor market for employees with the diverse skills we term administrative.

The attrition at the GS-5 entry level is particularly painful. When 27% of this group is lost annually, thousands of dollars in recruitment and training funds are wasted. The agency reaps nothing from this time and dollar investment. A significant number of the journey level staff are also leaving. This "brain drain" is doubly distressing when such high losses are also occurring at the entry level.

TECHNICAL

The technical category is also subject to tremendous turnover. The annual vacancy rate (vacant positions plus losses) is an astounding 38%. These figures are particularly disturbing at the GS-5 level (often a journey grade for technicians) shooting over the 50% mark! At the GS-7 level (the most populous technical grade) 4 out of 10 positions are vacant at some time during the year. Also at this critical level, only 14% of our open positions were filled. New York lost 723 technicians during the survey period - one in five. 45% of those losses were quits for pay**. Sadly, we were able to fill only 40% of the positions we tried to fill. Technicians in many areas are actively recruited; many by the firms doing business with their agencies. We provide a healthy pipeline that flows only one way!

** Many additional losses may qualify as quits for pay. Often the separation form does not accurately capture this information.

CLERICAL

The clerical employee provides the foundation of a healthy organization. Without a reliable and capable clerical employee agencies' clients wouldn't receive a claim check or a tax return; telephone inquiries would not be answered. In fact, organizations would come to a grinding halt! A good clerical staff is indicative of a healthy organization, therefore our statistics are foreboding. Over 50% of all the clerical positions surveyed are vacant during the year. We lost 37% of this workforce during the survey period.

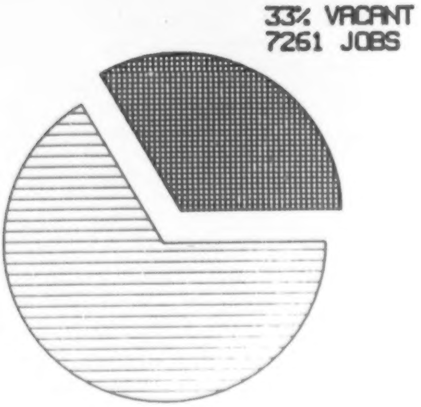
For purposes of testing applicants skills, OPM considers the clerical candidates as one labor pool. The current pass rate for the New York City clerical examination is 28%. Our spreadsheet indicates what happens to that 28% after the test. Only 39% of the offers made to this "pass group" are accepted. As stated earlier, 37% will leave federal service. All of this happens within a year.

Our administrative and professional personnel can no longer rely on the clerk for the traditional support in carrying out the work of the government. The time spent by these higher paid employees in performing clerical tasks because of the high vacancy rate is difficult to measure. However the statistics clearly indicate a lack of stability in the clerical ranks. The juggling which results has and will continue to lead to an erosion of service.

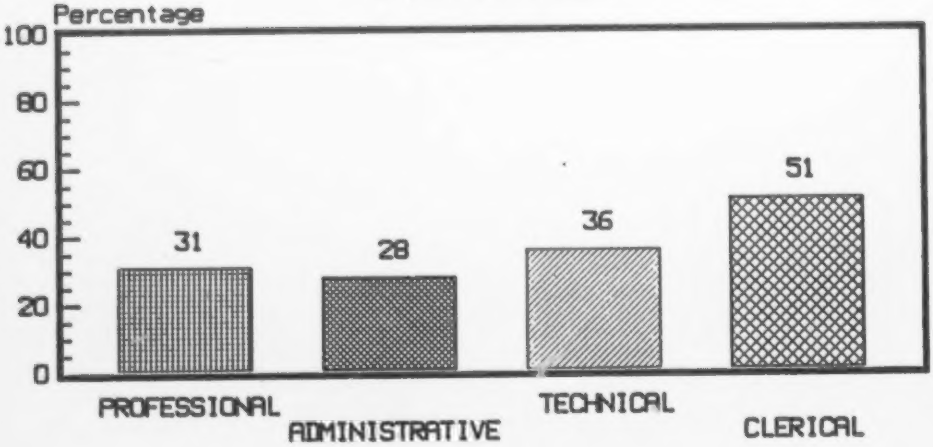
OTHER

This category is composed of only one series in our current submission - the 007 Correctional Officer. This narrative will be brief as the statistics are overwhelming. In NY, 150% of the series members left during the study period; 79% of the total population left this occupation for a better paying job. This occupation is a revolving door. By any standards special rates are imperative to try to stop this exodus.

ANNUAL VACANCY RATE
7/1/87 - 6/30/88
CONSOLIDATED SUMMARY OF 81 OCCUPATIONS
21,331 POSITIONS



ANNUAL VACANCY RATE
7/1/87 - 6/30/88
SUMMARY BY OCCUPATIONAL CATEGORY*
21,331 POSITIONS



*EXCLUDES "OTHER" CATEGORY

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: TOTAL SUMMARY

	BEGINNING SNAPSHOT JULY 1, 1987			ENDING SNAPSHOT JUNE 30, 1988			RECRUITMENT DURING PERIOD				TURNOVER DURING PERIOD		
GS GRADE	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	GS GRADE	POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	LOSSES	QUITS	QUITS FOR PAY
1	46	46	0	36	36	0	1	30	30	10	5	5	5
2	57	55	2	47	45	2	2	64	46	30	8	6	6
3	265	215	50	257	200	57	3	329	188	102	70	44	40
4	1479	1239	240	1554	1364	190	4	1199	2085	825	635	402	271
5	2574	1837	737	2831	2433	398	5	2008	2390	1254	540	388	275
6	1112	934	178	1105	893	212	6	381	71	47	98	66	39
7	2927	2344	583	3394	2682	712	7	1332	1290	783	462	277	226
8	522	465	57	582	474	108	8	88	101	28	78	57	45
9	2500	2146	354	2537	2155	382	9	609	652	308	356	193	151
10	430	419	11	401	354	47	10	28	22	3	156	100	81
11	3118	2739	379	3078	2716	362	11	625	710	331	413	191	155
12	2666	2347	319	2570	2336	234	12	482	551	262	338	195	163
13	1850	1753	97	1864	1769	95	13	204	231	119	183	97	74
14	1042	958	84	1019	961	58	14	127	140	72	89	55	21
15	378	370	8	382	369	13	15	33	39	21	41	25	13
ES	20	20	0	19	19	0	ES	0	0	0	0	0	0
TOTALS	20986	17887	3099	21676	18806	2870	TOTALS	7539	8546	4195	3472	2097	1565

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1			33%	33%	12%	12%	12%
2	0	0%	65%	47%	16%	12%	12%
3	112	44%	54%	31%	34%	21%	19%
4	950	61%	40%	69%	49%	31%	21%
5	1534	54%	52%	62%	25%	18%	13%
6	269	24%	66%	12%	11%	7%	4%
7	1512	45%	61%	59%	18%	11%	9%
8	195	34%	28%	32%	17%	12%	10%
9	747	29%	47%	51%	17%	9%	7%
10	138	34%	14%	11%	40%	26%	21%
11	752	24%	47%	53%	15%	7%	6%
12	561	22%	48%	54%	14%	8%	7%
13	294	16%	52%	58%	10%	6%	4%
14	150	15%	51%	57%	9%	6%	2%
15	53	14%	54%	64%	11%	7%	4%
ES					0%	0%	0%
TOTALS	7261	33%	49%	56%	19%	12%	9%

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: PROFESSIONAL SUMMARY

	BEGINNING SNAPSHOT JULY 1, 1987			ENDING SNAPSHOT JUNE 30, 1988				RECRUITMENT DURING PERIOD			TURNOVER DURING PERIOD		
GS GRADE	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	GS GRADE	POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	LOSSES	QUITS	QUITS FOR PAY
1			0			0	1						
2			0			0	2						
3			0			0	3						
4			0			0	4						
5	102	49	53	116	84	32	5	330	398	153	33	22	15
6	0	0	0	3	3	0	6	3	4	3	0	0	0
7	250	193	57	304	259	45	7	302	399	178	117	87	69
8			0			0	8				1	1	1
9	638	525	113	695	577	118	9	344	339	172	151	97	78
10	13	13	0	20	14	6	10	5	8	2	5	4	4
11	971	846	125	975	857	118	11	286	327	156	170	99	82
12	1069	923	146	999	898	101	12	255	310	110	153	97	87
13	987	921	66	979	924	55	13	106	134	58	103	58	51
14	289	276	13	288	279	9	14	29	41	19	34	25	18
15	146	146	0	145	139	6	15	16	20	7	21	14	12
ES	18	18	0	17	17	0	ES	0	0	0	0	0	0
TOTALS	4483	3910	573	4541	4051	490	TOTALS	1676	1980	858	788	504	417

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1							
2							
3							
4							
5	100	86%	38%	46%	50%	33%	23%
6	3	100%	75%	100%			
7	228	75%	45%	59%	52%	38%	31%
8							
9	321	46%	51%	50%	27%	18%	14%
10	12	60%	25%	40%	37%	30%	30%
11	299	31%	48%	55%	20%	12%	10%
12	229	23%	35%	43%	17%	11%	10%
13	161	16%	43%	55%	11%	6%	6%
14	46	16%	46%	66%	12%	9%	6%
15	20	14%	35%	44%	15%	10%	8%
ES					0%	0%	0%
TOTALS	1419	31%	43%	51%	20%	13%	11%

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: ADMINISTRATIVE SUMMARY

	BEGINNING SNAPSHOT JULY 1, 1987			ENDING SNAPSHOT JUNE 30, 1988				RECRUITMENT DURING PERIOD			TURNOVER DURING PERIOD		
GS GRADE	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	GS GRADE	POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	LOSSES	QUITS	QUITS FOR PAY
1			0			0	1						
2	2	0	2	2	0	2	2	2	0	0	0	0	0
3	10	2	8	6	1	5	3	109	15	3	3	0	0
4	206	113	93	200	80	120	4	147	184	89	15	12	9
5	466	330	136	711	589	122	5	573	624	425	126	105	74
6	2	1	1	2	1	1	6	0	0	0	0	0	0
7	1255	1055	200	1534	1321	213	7	597	594	452	117	69	59
8	315	276	39	314	273	41	8	1	2	0	38	35	25
9	1467	1275	192	1477	1242	235	9	212	262	123	175	89	67
10	362	351	11	318	290	28	10	19	13	0	149	95	76
11	2081	1830	251	2047	1808	239	11	332	342	172	229	98	72
12	1586	1417	169	1557	1433	124	12	226	239	152	103	97	75
13	859	828	31	880	840	40	13	95	94	58	79	39	23
14	751	680	71	729	680	49	14	98	99	53	55	30	3
15	232	224	8	237	230	7	15	17	19	14	20	11	1
ES	2	2	0	2	2	0	ES	0	0	0	0	0	0
TOTALS	9596	8384	1212	10016	8790	1226	TOTALS	2420	2407	1541	1109	672	484

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1							
2	2	100%		0%			
3	7	117%	20%	3%	200%	0%	0%
4	102	51%	48%	61%	16%	12%	9%
5	507	71%	68%	74%	27%	23%	16%
6	1	50%			0%	0%	0%
7	596	39%	76%	76%	10%	6%	5%
8	76	24%	0%	0%	14%	13%	9%
9	377	26%	47%	58%	14%	7%	5%
10	116	36%	0%	0%	46%	30%	24%
11	446	22%	50%	52%	13%	5%	4%
12	323	21%	64%	67%	13%	7%	5%
13	131	15%	62%	61%	9%	5%	3%
14	104	14%	54%	54%	8%	4%	0%
15	33	14%	74%	82%	9%	5%	0%
ES	0	0%			0%	0%	0%
TOTALS	2821	28%	62%	63%	14%	8%	6%

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: TECHNICAL SUMMARY

GS GRADE	BEGINNING SNAPSHOT JULY 1. 1987 TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	ENDING SNAPSHOT JUNE 30, 1988 TOTAL POSITIONS	ON BOARD	VACANT POSITIONS
1	46	46	0	36	36	0
2	14	14	0	8	8	0
3	79	75	4	78	78	0
4	611	528	83	584	539	45
5	1002	627	375	880	754	126
6	973	808	165	940	759	181
7	1317	1001	316	1447	1008	439
8	176	158	18	235	168	67
9	395	346	49	365	336	29
10	55	55	0	63	50	13
11	66	63	3	56	51	5
12	11	7	4	14	5	9
13	4	4	0	5	5	0
14	2	2	0	2	2	0
15			0			0
ES			0			0
TOTALS	4751	3734	1017	4713	3799	914

GS GRADE	RECRUITMENT DURING PERIOD POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	TURNOVER DURING PERIOD LOSSES	QUITS	QUITS FOR PAY
1	30	30	10	5	5	5
2	18	18	8	5	3	3
3	100	107	47	51	33	30
4	285	319	190	153	101	77
5	461	509	324	222	164	112
6	366	55	32	92	61	35
7	319	92	44	118	62	46
8	66	78	15	28	10	9
9	53	51	13	30	7	6
10	4	1	1	2	1	1
11	7	41	3	14	2	1
12	1	2	0	2	1	1
13	3	3	3	1		
14						
15						
ES						
TOTALS	1713	1306	690	723	450	326

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1			33%	33%	12%	12%	12%
2			44%	44%	45%	27%	27%
3	54	69%	44%	47%	67%	43%	39%
4	209	36%	60%	67%	29%	19%	14%
5	475	54%	64%	70%	[illegible]	24%	16%
6	224	24%	56%	9%	[illegible]	8%	4%
7	564	39%	48%	14%	12%	6%	5%
8	105	45%	19%	23%	17%	6%	6%
9	49	13%	25%	25%	9%	2%	2%
10	10	16%	100%	25%	4%	2%	2%
11	7	13%	7%	43%	25%	4%	2%
12	9	64%	0%	0%	33%	17%	17%
13	2	40%	100%	100%	22%	0%	0%
14	0	0%			0%	0%	0%
15							
ES							
TOTALS	1702	36%	53%	40%	19%	12%	9%

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: CLERICAL SUMMARY

	BEGINNING SNAPSHOT JULY 1, 1987			ENDING SNAPSHOT JUNE 30, 1988				RECRUITMENT DURING PERIOD			TURNOVER DURING PERIOD		
GS GRADE	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	GS GRADE	POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	LOSSES	QUITS	QUITS FOR PAY
1			0			0	1						
2	41	41	0	37	37	0	2	44	28	22	3	3	3
3	176	138	38	173	121	52	3	120	66	52	16	11	10
4	662	598	64	770	745	25	4	767	1582	546	467	289	185
5	1004	831	173	1124	1006	118	5	644	859	352	159	97	74
6	137	125	12	160	130	30	6	12	12	12	6	5	4
7	53	53	0	41	41	0	7				12	5	4
8			0			0	8						
9			0			0	9						
10			0			0	10						
11			0			0	11						
12			0			0	12						
13			0			0	13						
14			0			0	14						
15			0			0	15						
ES			0			0	ES						
TOTALS	2073	1786	287	2305	2080	225	TOTALS	1587	2547	984	663	410	280

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1							
2			79%	50%	8%	8%	8%
3	51	29%	79%	43%	12%	8%	8%
4	639	83%	35%	71%	70%	43%	28%
5	452	40%	41%	55%	17%	11%	8%
6	41	26%	100%	100%	5%	4%	3%
7	0	0%			26%	11%	9%
8							
9							
10							
11							
12							
13							
14							
15							
ES							
TOTALS	1182	51%	39%	62%	37%	23%	16%

SPECIAL SALARY RATES
NEW YORK CITY

SERIES: OTHER SUMMARY

	BEGINNING SNAPSHOT JULY 1, 1987			ENDING SNAPSHOT JUNE 30, 1988				RECRUITMENT DURING PERIOD			TURNOVER DURING PERIOD		
GS GRADE	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	TOTAL POSITIONS	ON BOARD	VACANT POSITIONS	GS GRADE	POSITIONS TRY FILL	OFFERS MADE	NUMBER HIRED	LOSSES	QUITS	QUITS FOR PAY
1			0			0	1						
2			0			0	2						
3			0			0	3						
4			0			0	4						
5			0			0	5						
6			0			0	6						
7	52	42	10	68	53	15	7	114	205	109	98	50	48
8	31	31	0	33	33	0	8	21	21	13	11	11	10
9			0			0	9						
10			0			0	10						
11			0			0	11						
12			0			0	12						
13			0			0	13						
14			0			0	14						
15			0			0	15						
ES			0			0	ES						
TOTALS	83	73	10	101	86	15	TOTALS	135	226	122	109	61	58

SUMMARY

GS GRADE	ANNUAL VACANCY NUMBER	ANNUAL VACANCY RATE	OFFER ACCEPT RATE	FILL SUCCESS RATE	LOSS RATE	QUIT RATE	QUIT FOR PAY RATE
1							
2							
3							
4							
5							
6							
7	124	182%	53%	96%	206%	105%	101%
8	13	39%	62%	62%	34%	34%	31%
9							
10							
11							
12							
13							
14							
15							
ES							
TOTALS	137	136%	54%	90%	149%	84%	79%

May 1, 1989

Mr. E. S. Kenton
1C LaBonne Vie Drive
E. Patchogue, NY 11772

D.A.V. Life Member
No. 31190L29567
SS# 130-09-0596
Claim No. 23693810
Member Local Chapter AARP

Hon. G. V. (Sonny) Montgomery, Chairman
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Sir: -

I am 100 percent rated by the V.A. for a nevrous disorder. I take "Fee Basis" treatment for the above condition paid for by the V.A. on a weekly basis to Robert M. Derman, M.D., psychiartrist, at 33 Landing Lane, Port Jefferson, New York 11777.

As a result of an article, however short, in Newsday on April 3, 1989 and a subsequent press release dated March 17, 1989, subject: Congressman Robert Mrazek, Third District, New York, would chair hearings through congressional subcommitees on the problems of the Veterans Administration Medical Center in Northport, New York. This meeting will take place on Monday, May 15, 1989, at 9 a.m. in building 5. A copy of this release is enclosed. It is labeled A. "AMONG the issues to be discussed is the facilities inability to hire adequate personnel at federal wage rates."

In the summer of 1987, I contracted Pneuemonia . I entered as an inpatient in Unit 34, building 200, Northport. The head nurse, a gentleman by the name of Rick, was in charge of the overall during the day shift. The treatment that I received, as well as others in that unit, was exceptional. The reason being that he had, as well as in all the other shifts, another RN to work with, at least 2 LPNs, and 1 or 2 nurses' aids. At that time the emphasis was on patient care.

The above paragraph is drawn to your attention in contrast with my having incurred a cancer on the right side of my tongue. I entered Unit 21 on February 14 and was released after being in ICU first and then into one of the rooms in Unit 21. I was discharged through outpatient care on the 25th. I was told by my surgeon, Dr. Mawulawde, to return in March for the removal of the lymph nodes on the right side of my neck. At that time I was in Unit 22. Dr. Mawulawde was again my surgeon, and the lymph nodes were removed quite successfully without need for chemotheraphy or radiation. As a result of this experience, I found it necessary to send a letter to Mr. William H. Manley, Director, commending Dr. Mawulawde's efforts on my behalf when he was with the VA Surgical Service. Enclosue B is the letter I received from Mr. Manley expressing his remarks to me. I sent another letter of commendation to Harry S. Soroff, M.D. Mr. Soroff's letter of acknowledgment is enclosed and labeled C. In order to have creditability, the submission of letters B and C should be taken into account.

In 1985 and 1986 I was in a program at Northport known as Incentive Theraphy. John Hane was my therapist. In that program I went to VA three times a week. They placed me in escort, where I took inpatients to treatment areas, i.e. from Unit 33 to Radiology in building 200. Because of my desire and efforts, I was given a more responsible job in the program working under Mrs. Karen Jenkins, the Head of Specialists, in building 2, 2nd floor. In that capacity, I was able to, along with others, glean charts from the file room and bring them to the different clinics. During that whole experience with regard to the Incentive Theraphy program and the period in Unit 34, I was able to make some observations to wit. The ability to give proper care, to both in and outpatients, has been seriously threatened by severe cutbacks. Four copies of computer printout of notice to check recipient prior to the cutbacks are enclosed and labeled D. Patient care has suffered greatly. The lack of funds for hiring more people has created a great deal of pressure on all areas concerning staff. One of the RNs who * I knew when I was in the Incentive Theraphy program made a statement to me on April 2, 1989 concerning the director of nursing. Mr. Neville hardly ever makes rounds and the RNs, generally speaking, to this date "don't even know what he looks like." I have been advised that Mr. Neville sends out is "edicts" to the enitire nursing staff and to this date has been employed for almost a year. * The aforementioned RN's name out of necessity is priveleged information.

On April 6, 1989, I had an appointment with the medical clinic in building 2. My regular chart number 3 of 3 was not available. Dr. Prasad had NO way of being able to go back in my medical history. I had to give him the information verbally.

2

Enclosure E refers to a form for medications refills.

Enclosure F dated April 3, 1987 refers to changes in the Beneficiary Travel Program to receive treatment from Dr. Derman.

Enclosure G dated March 1, 1989 refers to a claim received for travel reimbursement. As a result of Public Law 100-322, my claim for travel reimbursement was denied. It was signed by Mr. Semple for Mr. Juliano. This was Mr. Semple and his superiors own interpretation of Public Law 100-322. To this date I have not received one penny even though a cap of $18 a month had been authorized and changed effective April 1. The new cap is $6 a month. In essence, Travel should be authorized for fee basis treatment using the same methodology for each.' Enclosure H is a voucher showing the $18 cap deductible, 3 visits, and a net to me of $1.14 dated March 8, 1989.

I attended a town meeting on April 17 at the South Country Library in Bellport. I had an opportunity to address the problems of Travel. I stated that that law was loosely interpretated by the V.A. and that, indeed, the law had changed as of April 1, 1989. I spoke with a woman named Barbara from the Centereach office of Congressman Hochbrueckner outside of the discussion room. I asked her what she gets to come to South Country Library. She receives 20 cents a mile while veternans receive 11 cents a mile for traveling expenses. This is just AN aspect of the inadequacies veternans face.

Further cutbacks have imposed additional restrictions. Enclosure I refers to the fact that there is no longer a provision for postage free business reply mail envelopes for refill requests.

Enclosure J dated January 6, 1985 refers to identify my membership to the V.A.

Enclosure K is the front cover of a DAV magazine dated April 1989 which talks to Edward J. Derwinski, the nation's first Secretary of Veterans Affairs. More important is the lower part of the cover showing a picture of DAV vans. More DAV vans are donated to VA medical facilities nationwide from DAV National Headquarters, which obviously demonstrates the further lack of interest on the part of the government as regard to those who are incapable of getting to VA on their own.

Enclosure L are original news clippings from Newsday, Weekender, and AARP News regarding VA hospitals in Northport.

Mr. Manley has seen fit to spend funding, which should go for patient health care, on putting new wallpaper in the main floor of building 200, and putting ceramic tile on the walls at the entrance of E.T.A. Unit 21 has been redone and the only real important thing that took place was to lower the handle levers in the bathrooms so they were reachable. These are just a few of the, what I refer to, as cosmetic indulgences to make building look better while health care continues to suffer.

I allude to the above by being specific. On February 28 a patient in the bed opposite me in Unit 22, Robert Rosenhaus, was not able to be helped to the bathroom in order to have a bowel movement. Unable to contol his movement the bottom of his pajamas was soiled and will never change. There are not enough people to tend to the needs of the patients.

Enclosure N refers to a Newsday article dated February 8, 1987. The facility in Northport has been finished and is waiting for occupancy. Instead of being a nursing home for older veterans, the facility is now being turned into offices to handle the increase of Stony Brook medical students.

Enclosure N refers to a Newsday article published March 29, 1989. A Veteran is pictured looking at Valentine Day cards sent by the children from schools in proximity. Valentine's Day is February 14.

Enclosure O dated June 24, 1988 to Congressman George Hochbrueckner at his local office from the district of the Navy, Personnel Records Center. Paragraph three shows that I earned a Bronze star for service aboard the USS LOWE (DE-325), and I was subsequently advised that the department of the Navy was no longer supplying Bronze stars. I would now have to go out and purchase my own at an Army and Navy store.

Sir, I humbly implore you not only on my part but for all disabled veterans who have earned an entitlement and who are being considered second class citizens, to consider these submissions as being vitally important.

I, for one, am extremely appreciative of the opportunity to have my written statement placed in the printed record.

Most sincerely yours,

Erwin S. Kenton

Enclosures

THE ASSEMBLY
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COMMITTEES
EDUCATION
HEALTH
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May 15th, 1989

Testimony - John J. Flanagan

Suffolk County Veterans Hearing
V.A.Hospital, Northport, New York

When news of the proposed closing of two long-term care wards at the Northport Veterans Administration Hospital first came out in March, I joined with the fifteen other Republican Assemblymen who represent Long Island in urging the federal Secretary of Veterans Affairs, Edward Derwinski, to reconsider the $2 million spending reduction to veterans programs upon which Northport Hospital officials based their decision to close the wards.

We were disappointed that hospital officials considered the ward closings, and that despite the need for federal fiscal restraint that any reductions in support to veterans are under consideration.

In view of the fact that federal funding to veterans has not been increased since 1977 and that New York State now operates only one veterans' nursing home (in Chenango County), the closure of the long-term care wards at Northport would be an effective abandonment of the commitment we owe our veterans.

Long Island has the largest veterans population in the state, and this is primarily a population of men and women who served our country in World War II and Korea. Because these veterans are now in their sixties and seventies, their health care needs are among their most critical concerns. Of the estimated two million veterans in New York State, nearly half a million of them are age 65 or older. Even with the anticipated construction of a second state-run veterans' home in Suffolk County, our health care support for these aging veterans is sadly lacking.

Approximately 80 patients from the Northport facility will be directly affected in the event of long-term care ward closings there. The high cost of individual home care or private nursing home care will make adequate health care for these 80 veterans an extreme financial hardship. Adequate care for some may very well become impossible.

When our veterans entered the service of our country, they did so with confidence that we would provide for their needs in later years. We made an unimpeachable commitment to our servicemen and women. We cannot abandon that commitment at the first sign of difficulty.

Republican Assemblymen have sponsored a number of bills to improve the long-term health care system for veterans, including several feasbility studies to determine where state facilities can be constructed or expanded. **We support these efforts in spite of state or federal budget problems.** Our debt to veterans is that high.

Today, I call for full restoration of proposed spending reductions to veterans programs and urge hospital officials to provide for the ongoing care of veterans who now reside at the Northport facility. In addition, local, state, federal and veterans' officials need to cooperate more fully in setting clear, consistent policy for the protection of veterans services. Anything less would be a grave and serious failure.

Thank you to Congressman Mrazek for holding this hearing and for recognizing the importance of this critical issue.

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

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DEPUTY MINORITY WHIP

COMMITTEES
ENERGY
ENVIRONMENTAL CONSERVATION
LOCAL GOVERNMENTS

CONTACT
☐ ALBANY OFFICE
☐ DISTRICT OFFICE

WRITTEN TESTIMONY SUBMITTED TO:

Public Hearing on the Proposed Closing of
Northport Veterans Hospital Long Term Care Ward

Sponsored by Congressman Mrazek (sp)

Monday - May 15, 1989

As a result of the attached letter to the Federal Secretary of Veterans' Affairs and similar local community efforts, officials of the Northport Veterans Hospital decided to reconsider the original decision to close the long term care wards at Northport Veterans Hospital.

Recognizing that Long Island has the largest veterans' population in the state and that only one state-run nursing home for veterans currently exists, Nassau County Republicans today reaffirm our commitment to full support, including proper health care, for our veterans.

We call for the restoration of the proposed $2 million spending reduction upon which the decision to close the Northport facilities is based, and we implore hospital officials to provide for the continued care of veterans now residing in these facilities.

Respectfully submitted by: The Nassau County Republican Delegation

(Enclosure)

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

March 1989

Edwin Derwinski
Secretary of Veterans Affairs
Veterans Administration
810 Vermont Avenue NW
Washington, DC 20420

Dear Mr. Derwinski:

When budgetary constraints cause us to ignore the needs of our citizens, we will have reached a point when government becomes the discretionary benefactor of a select few, responsible for nothing but empty promises.

Recent funding cuts for Veterans Administration hospitals, which will force veterans with long-term health needs to fend for themselves, are clearly if not intentionally, a case of misplaced priorities and harmful government insensitivity to our most deserving citizens -- our veterans -- whose services secured our liberties.

As representatives of many veterans living on Long Island, we feel a sense of responsibility to these brave men and women who risked their lives for their country, only to be told that their country will no longer compensate them for the fulfillment of their duty.

Federal funding cutbacks totalling $2 million have forced the administration of Northport Veterans Hospital to close two long-term care wards, which presently serve the needs of veterans who ask only for fairness and compassion. But what do they receive? Approximately 80 patients in the care wards are threatened with eviction even though the hospital's director indicated "most of them" would be "accommodated in some way." We oppose such a callous "policy" for even a single veteran for whom the alternative is individual home care or nursing home care. Even with Medicaid assistance, these honored veterans will see their savings depleted and life quality degraded.

Although we respect the need for budgetary spending constraints, as well as the dilemma caused by the combination of rising medical costs and the growing elderly population, we refuse to believe that we can disregard the needs of our elderly veterans. Their continued care must be protected.

Many veterans entered active service duty with the small, but important, comfort of knowing that their health care needs would be taken care of in later years. Were these servicemen and women wrong? Or were they lied to? Can we do less and expect self-respect as a people?

We trust that the current situation is the mistaken result of temporarily misplaced priorities, and we were encouraged by the re-evaluation of the degree of the cutbacks released subsequent to the original Newsday story.

We do not need to bestow empty honors upon our veterans. We need to help them, as they helped us, in a time of need.

cc: William Manley
Director of Northport Veteran's Administration Hospital

Respectfully Submitted,

Robert C. Wertz
ROBERT C. WERTZ

John L. Behan
JOHN L. BEHAN

Fred Parola
FRED PAROLA

PHILIP B. HEALEY

Daniel Frisa
DANIEL FRISA

George H. Madison
GEORGE H. MADISON

Robert J. Gaffney
ROBERT J. GAFFNEY

Thomas F. Barraga
THOMAS F. BARRAGA

John C. Cochrane
JOHN C. COCHRANE

John J. Flanagan
JOHN J. FLANAGAN

James D. Conte
JAMES D. CONTE

Gregory Becker
GREGORY BECKER

John Powell
JOHN POWELL

Charles J. O'Shea
CHARLES J. O'SHEA

Joseph Sawicki Jr.
JOSEPH SAWICKI JR.

Kemp Hannon
KEMP HANNON

Members of the New York State Assembly
Long Island Delegation

TESTIMONY

OF

JAMES CONTE
ASSEMBLYMAN - 10TH A.D.

Our veteran population is agin. Many of these veterans served in World War II and Korea, wars that are almost beyond the memories of the new generation of Americans.

Yet with the onset of age, the needs of veterans also grow, particularly in the field of health care. Of the approximately two million veterans in New York State approximately 438,000 are age 65, or older. Their health care needs, including nursing home care, will require a dedicated commitment from the government, at the federal, state and local levels, as well as from communities and individuals.

In light of this situation and the need for governmental leadership and assistance on the issue, the closure of Northport Veterans Administration Hospital's long-term health care wards is fully contradictory to the proper role of government.

Upon learning of the proposed closing in March, my Republican Assembly colleagues and I sent a letter to the federal Secretary of Veterans Affairs, Edward Derwinski. In our letter we implored the secretary to reconsider the $2 million funding cutback that would force the closure of the long-term care wards at Northport V.A. Hospital.

Our letter stated that despite our respect for "budgetary spending constraints, as well as the dilemma caused by the combination of rising medical costs and the growing elderly population, we refuse to believe that we can disregard the needs of our elderly veterans." We concluded our letter by reiterating that "we do not need to bestow empty honors upon our veterans. We need to help them, as they helped us, in a time of need."

I stand firmly behind this position.

Currently, New York State has only one state veterans home, located in Chenango County. A second is now being constructed in Suffolk County, with an anticipated completion date in 1990.

The question we must ask ourselves: Is this sufficient?

Unfortunately, the answer is that it is not sufficent. Yet, because of tight fiscal policies at the federal and state levels, we are being told that it will have to be sufficient. In other words, it is sufficient on paper, regardless of reality.

Is there an alternative? The only alternative for the patients at Northport V.A. Hospital will likely be nursing home care. Yet even if a veteran can find such care, and a shortage does exist, it may be unaffordable. Even with Medicaid assistance, veterans using these options will likely see their savings depleted and their quality of life degraded.

As we stated in our letter: "When budgetary constraints cause us to ignore the needs of our citizens, we will have reached a point when government becomes the discretionary benefactor of a select few, responsible for nothing but empty promises."

The $2 million funding cut will force the administration of Northport V.A. Hospital to close two long-term care wards which serve the needs of 80 patients. These patients will likely be evicted.

When these veterans entered the service, they did so with the small, yet important, comfort of knowing their health care needs would be taken care of in later years. Yet now, as they reach those later years, we renege on our promise.

In the New York State Assembly, we have proposed numerous bills to advance the cause of long-term veteran health care. Our efforts have requested feasibility studies on new state facility construction and the establishment of certain new long-term care facilities. Unfortunately, we have not succeeded in advancing these proposals.

One of the major obstacles to meeting the growing need for long-term veteran health care, which most of us recognize as an imperative need, is the reluctance of any group or government agency to accept responsibility and set proper policy. As I said earlier, the effort requires a dedicated commitment, a shared commitment, from various agencies at all levels of government and the people.

I believe the people support proper care for our aging veterans, feeling a sense of responsibility and honor for the brave men and women who protected our nation against outside threats. However, fiscal austerity at the governmental level is causing many agencies to shy away from the policies they know are needed. And it is preventing proper policy from being implemented.

We cannot let fiscal authority lead us backwards, however, as will occur if the long-term care wards at Northport V.A. Hospital are closed.

Although there is no need to assess blame, though maybe there is cause to share blame, one factor which cannot be overlooked is the role of the federal Veterans Administration. As the operator of the nation's largest hospital system and a a provider of veterans nursing home care, the V.A. influences all policy at lower levels, including the state level. With control over specific funding mechanisms, the V.A. often sets the parameters for state policy and funding.

Our veterans ask for our help now, as we asked for, and demanded, their help in the past. We need to restore the $2 million in funding to ensure that Northport V.A. Hospital has the ability to provide appropriate long-term health care for veterans.

We have reached the "time of need" for veterans. We cannot afford to turn our backs.

Thank you.

Eastern Paralyzed
Veterans Association

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EPVA

Testimony Submitted for the Record

by

EASTERN PARALYZED VETERANS ASSOCIATION

75-20 Astoria Boulevard

Jackson Heights, NY 11370-1178

to

The House Veterans Affairs Committee

Subcommittee on Hospitals and Health Care

Northport Department of Veterans Affairs Medical Center

Northport, New York

on

Monday, May 15, 1989

Good Afternoon Chairman Morrison, and Ranking Minority Member Rowland. My name is James J. Peters, Executive Director of the Eastern Paralyzed Veterans Association (EPVA). Thank you for the invitation to appear today. EPVA is privileged to have this opportunity today to discuss the effects of budget constraints on the quality of veterans' health care services.

EPVA is a chapter of the Paralyzed Veterans of America (PVA) which is a congressionally chartered veterans's service organization. All of our members have either an injury or disease of the spinal cord. Our membership is located throughout Connecticut, New York, New Jersey and Pennsylvania.

Since World War II there have been tremendous medical advances which have greatly increased the life expectancy of an individual with a spinal cord injury. The development of effective antibiotics have lifted the potential death sentence facing the disabled community. This positive step, has brought on many problems in dealing with quality of care issues.

The quality of care issue has a direct impact on the Northport catchment area, especially on available long-term beds. It is appropriate that this hearing is being held in the Northport DVAMC. This area has a large population of WWII veterans, many of whom will be needing long-term care in the near future. The VA has not provided the necessary beds and the state does not have the necessary resources to provide a reasonable alternative. As the VA must close beds due to improper staff resources, veterans are being sent to their homes with no provision for care, or to community nursing homes at their own expense. The plans developed only a few short years ago to provide a mixture of various resources for long-term care have been abandoned, and the veteran is left with few available alternatives.

In our testimony, we will be discussing the Department of Veterans Affairs (DVA) budget, the quality of Veterans Health Care, ideas for improving retention and recruitment, and EPVA's pending lawsuit against Castle Point Veterans Medical Center.

DVA BUDGET

During the past few years the DVA has consistently submitted insufficient requests for funding to the Congress. The process has pushed the DVA into a crisis situation from which it may never recover. The DVA facilities are all suffering from inadequate funding and are being forced to borrow money from other accounts to keep the facility running. This practice has reached epic proportions and now threatens the long term future of the veterans health care system.

The Veterans' Service Organizations have long advocated for adequate funding of veterans medical programs. It was apparent to them that something had to be done to address the Administrations continued practice of submitting inadequate budget proposals to the Congress. Therefore, in response to this growing concern, PVA, along with AMVETS, Disabled American Veterans and the Veterans of Foreign Wars, developed "The Need is Now: An Independent Budget by Veterans for Veteran's Program." This document has been well received and is becoming an integral part of the budget process.

The Independent Budget takes a hard look at all of the DVA's programs and advocates for money that will just keep the programs running at last years levels. This is a realistic approach in a time of fiscal constraints facing all Americans. However, the inadequate requests for funds each year, has put the DVA in a very difficult position. The increases must exceed the normal increased costs in order to make up for years of shortfalls. The local facilities have run out of "fat" and are facing numerous problems keeping beds open. This situation should not be allowed to continue.

The current Fiscal Year budget is already expected to have a $600 million shortfall. EPVA supports the supplemental appropriation being considered in the House and Senate and which is supported by the White House. Although the supplemental is not enough, it will spare the DVA many hard choices, such as the closing of facilities, eliminating additional beds, or laying off of much needed staff.

It's imperative that the DVA Fiscal Year 1990 Budget include the increases passed in any supplemental appropriations. If it doesn't, the budget will already be facing severe problems before it takes effect, since it will be based on an inaccurate projection of need.

The Independent Budget Proposal calls for an $31.297(B) budget, which would allow the DVA to provide services at last years level. No new programs would be supported and the DVA would have to make do. Unfortunately, the Senate Budget Resolution Outlay is $29.988(B) and the House Budget Resolution is $29.975(B). Both of these figures, if passed, will not provide for adequate funding to ensure that veterans receive, at a minimum, services equal to last years. This continued reduction of service will lead to a further erosion of the care given at DVA facilities and will eventually lead to the dismantling of the current system.

QUALITY OF VETERANS HEALTH CARE

The budget crisis and the fiscal constraints over the last several years have affected the way the DVA delivers health care. The issue of quality of care continues to be on everyone's mind.

In return for service, the nation promised health care to those who served in the armed forces. As a result, one of the largest health care systems in the world was created. Tremendous leaps in medical care and technology have been made in the VA system because of the dedication to research and training. However, today that very system is in a crisis.

EPVA has always made veterans health care our number one priority. The level of deterioration in the DVA system has reached critical levels which are affecting the veteran population each and every day. The crisis demands immediate attention or we will lose a health care system that has always be rated as one of the best in the world.

The DVA's ability to deliver adequate medical services to our nation's veterans has slowly but steadily deteriorated. Shortages of critical medical services are being felt throughout the VA's medical system.

EPVA, as well as individuals in the DVA health care system, are convinced that the system is losing its control over the quality of care it is delivering. Several indicators related to quality lead us to this conclusion. They include staff shortages, recruitment and retention problems, lack of funds to purchase such medical devices as artificial joints, unwarranted delays in the purchase of prosthetics and medical equipment such as wheelchairs, and increasing amounts of nursing overtime.

The DVA continues to deny care to non-service connected veterans with a more restrictive use of the "obviate the need" criteria. This can only cause more serious and costly problems to occur by delaying treatment and force a much longer hospitalization once the veteran is finally admitted for care.

A burgeoning backlog of medical equipment replacement needs, continues to grow. Many facilities continue to use discretionary funds to support nondiscretionary reoccurring base requirements. Reductions to staff in such critical supporting areas as prosthetics and building maintenance have all contributed to the decline of quality. These indicators are present across the system and have been substantiated through evidence accumulated by PVA during the past year, much of which was made available to the House and Senate Veterans' Affairs Committees at their hearings on the VA "Shortfall" (September 7 and 9, 1988).

DVA Medical Centers (DVAMCs) with spinal cord injury (SCI) units, such as Castle Point and Bronx, New York and East Orange, NJ are facing many serious problems. The demand for SCI unit services is tremendous. We have found that SCI units are cutting back services, because of lack of funding and staff. In some cases, DVAMC's are eliminating the number of available beds in the SCI units, while veterans are being placed on waiting lists. These beds are eliminated in violation of Congressional mandates. The funding originally allocated for these beds, which as you already know, are referred to as "phantom beds", is then spent on operating funds. These beds exist only on paper. Because of severe staff shortages caused by critical system-wide funding shortfalls, they are not providing necessary medical care.

Inadequate funding levels have ravaged the VA's ability to maintain bed levels, staffing levels, and timeliness in the provision of essential medical services. The shortage of staff at DVAMC's is increasing pressure on existing staff, thus multiplying their workload to unmanageable levels. Dangerous situation for patients are being created because of the staff's inability to spend adequate time with each patient in providing them with the proper medical care.

Recruitment and Retention

The staffing at DVAMC's is becoming another serious problem. There is a nationwide shortage in nursing and demand continues to grow. The DVA's efforts have produced minimal results since the lack of authority to be competitive restricts efforts to recruit and retain DVA nurses. Resolution of this problem must be given a top priority. Legislation to address this concern has been introduced by the Chairman of the House Veteran's Affairs Committee, Sonny Montgomery and Representative Kennedy.

The "Veterans' Health Care Programs Amendment of 1989", HR-901 sponsored by Chairman Montgomery would significantly improve the DVAs' ability to recruit and retain nurses and other "hands on" health care personnel. The provisions included in this legislation would go a long way in relieving the critical shortages being experienced by DVAMC's in these important health-care fields.

There are two sections of the bill that we would like to discuss.

SECTION 101 SPECIAL PAY FOR NURSES

EPVA supports and firmly believes that the incorporation of "special pay for nurses" is critical in the overall enhancement of the nursing program. DVA can only attract and retain these individuals if they are properly compensated for their expertise and special abilities. By addressing such issues as tenure, overtime, professional expertise, and other special attributes, you have properly included these individuals in the "highly qualified" category along with physicians and dentists.

SECTION 102 PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSES ASSISTANTS.

EPVA supports this section, which would enhance compensation for licensed practical and vocational nurses and nurse assistants. These professionals would then be appropriately elevated to a level of premium pay which would truly reflect their worth. The importance of trained and qualified nurses' assistants cannot be understated. They are at the core of providing much needed services to spinal cord injured veterans. This is an extremely difficult job and appropriate pay is necessary to keep these individuals adequately compensated.

DVAMC's must be able to compete with private-sector hospitals if they are to get a fair share of the ever-dwindling pool of health-care personnel.

The second bill to address the issue of recruitment and retention is the "Veterans Nurse Pay Act of 1989", HR-119, sponsored by Representative Kennedy.

EPVA supports the provisions contained in HR 1199. This bill, in conjunction with HR 901, provides meaningful incentives that encourage the recruitment and retention of nurses. It also enhances the potential for career opportunities while recognizing "time-in-grade" longevity of the professional health care personnel.

Especially important is the provision for inclusion of geographic cost-of-living pay differentials. This provision is especially important for DVA facilities in our area. These DVAMC's are facing an uphill battle in recruiting and retaining nurses, because of the higher cost of living.

EPVA strongly endorses both initiatives in H.R. 901 and HR 1199. They make much needed improvements to enhance DVA recruitment opportunities in the areas of nursing and other medical personnel.

EPVA LAW SUIT

The budget constraints and the breakdown in providing quality of care has taken its toll on everyone. Extreme frustration over the poor patient care at the Castle Point Veterans Administration Medical Center in Wappingers Falls, New York forced EPVA to file a lawsuit against the DVA. We have been forced to seek judicial assistance in order to ensure that spinal cord injured patients at Castle Point receive adequate care. The administration at Castle Point is aware that we are unsatisfied with the care and treatment provided to spinal cord injured veterans at the spinal cord injury center. Despite this knowledge, the administration has done little to improve conditions.

We conducted our own survey of the inpatients at the Medical Center and directly observed and identified problems at the Castle Point DVAMC, which must be remedied. These include, but are not limited to, the following:

- The supply service, as opposed to the medical professionals, dictates the availability of certain supplies, such as indwelling and condom type catheters. These decisions are, therefore, based on financial rather than medical criteria.
- Patients receive bowel care in bed. This is degrading since other patients find it offensive and make insulting remarks. This practice retards rather than furthers the rehabilitation of the SCI patient.
- The availability of baths and showers is extremely limited, due to staff shortages.
- Physical, occupational, corrective, and educational therapies, as well as driver training, are not provided at levels sufficient to meet patient needs.
- The Castle Point VAMC delays transfer of SCI patients for annual examinations and/or other care because it has closed down SCI beds, due to lack of staff.

It is apparent to EPVA that other SCI centers afford better treatment to SCI patients than is afforded at the Castle Point DVAMC. Attempting to use the law to remedy this disparity of treatment presents EPVA with a problem unique to organizations and individuals seeking to sue the DVA. Even though the DVA is a creature of statute and subject to the laws of the United States, veterans do not have the ability to seek judicial relief when they are aggrieved by DVA action, at least insofar as enforcing Title 38 of the United States Code, the law that directly affects the DVA. The DVA adopts regulations to implement the congressional mandates expressed in Title 38. A portion of the Title 38 regulations is called the "The Patient's Bill of Rights." Even though the DVA has afforded patients' rights, and has specified what they are in the Title 38 regulations, the laws of the United States prohibit veterans from using these regulations affirmatively to seek relief in the courts.

Therefore, EPVA will make claims based on laws other than those contained in Title 38 of the United States Code, or the Code of Federal Regulations. Since the DVA is a department of the federal government, the Fifth and Fourteenth Amendments of the United States Constitution provide EPVA with a basis for litigation. When the VA denies or withholds from a veteran a benefit or service, or treats certain veterans in a disparate manner, it does so under "color of law." These actions violate the due ~~process and~~ equal protection clauses of the Fifth and Fourteenth Amendments. As a federal department, the VA is subject to constitutional claims.

EPVA has reluctantly taken legal action against the DVA to remedy the current situation at Castle Point. EPVA's primary objective is the provision of quality care and treatment for those with spinal cord injuries. EPVA could not tolerate the hospital's neglect of patients' needs and disregard of patients' rights. To do so would simply invite further abuse.

It has always been EPVA's belief that the DVA spinal cord injury units provide the best spinal cord injury care in the nation. In order to maintain the quality of care that spinal cord injured veterans treated at Castle Point deserve, EPVA has taken legal steps to force the DVA to improve conditions.

EPVA has a major commitment to ensure that all veterans receive quality health care. As stated above, we are greatly concerned over the deteriorating conditions in services and supports at DVA medical centers. It's not enough to just sit back and wait for change. The following illustrates our commitment, by describing some of our activities aimed to ensuring quality health care in the DVA:

- Recently dedicated at Yale/West Haven, a new Neuroscience Center which focuses on the ways in which the nervous system adaptively responds to injury. Our $750,000 commitment is aimed at bringing about a cure for spinal cord injury and disease.

- At the Castle Point VA Medical Center, we have just funded the construction of a specialized bed service for plastic surgery for spinal cord injured veterans. We have also endowed the New York Medical College, which is affiliated with Castle Point VAMC, in the amount of $500,000 to provide speciality coverage for the Castle Point plastic surgery program. In addition, we annually fund a resident, a fellow and a student from the medical school of function full-time at the Castle Point facility.

- At the Bronx VA Medical Center, we have in the recent past purchased a lithotripter through partial funding of a joint project with the Mount Sinai School of Medicine, amounting to approximately 2 million dollars; we purchased a lasertripter which cost us approximately $200,000; we have endowed the Mount Sinai School of Medicine, which is affiliated with the Bronx VAMC, $500,000 to provide specialty urological coverage for neurourology in spinal cord injury care; we directly fund the services of a fellow in the Spinal Cord Injury Service, a resident in geriatrics, a resident in urology, as well as provide research funding in the area of urology. In addition, we also annually fund a nurses' education program for speciality care through Mount Sinai School of Medicine and, lastly, we have pledged to support 1/6 of the cost of a therapy program to provide therapists to care for the patients at the Bronx VAMC.

- At the East Orange VA Medical Center, we have joined with the New Jersey School of Medicine, Department of Rehabilitation Medicine, to fund the development of a rehabilitation program which includes direct funding of a full-time resident for the spinal cord injury service at the East Orange VAMC.

In addition to the above direct hospital programs that deliver first hand benefits to our spinal cord injured and deceased members, the Eastern Paralyzed Veterans Association totally funds and operate three organizations: The American Paraplegia Society, which is an organization of physicians numbering over 400 medical doctors involved in SCI care; the American Association of Spinal Cord Injury Nurses, which includes a membership of approximately 2,000 nurses involved in full-time SCI care; the American Association of Spinal Cord Injury Psychologists and Social Workers, which includes approximately 500 psychologists and social workers involved in spinal cord injury care. The funding of these organizations includes sponsorship of each member's participation at their annual symposium as well as publication of each organization's journals, educational materials, continuing education programs, peer review, and research programs.

As you can see, we are committed to quality medical care. Because of this commitment to Veterans Health Care, it is totally unacceptable to us to see the deplorable conditions in our hospitals and the deterioration of care.

This concludes our testimony. It was a pleasure being here today to discuss the current problems facing our veterans facilities. If you have questions, I would be more than happy to answer them.

Thank you.

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